

## Exhibit B

### 2023 Labcorp Personal Choice Benefits Handbook

# 2023 Labcorp Personal Choice Benefits Handbook

January 1, 2023

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## Coverage At A Glance

	BENEFIT PLAN		
	Medical Plans (Coverage Options Vary By Location)	Dental Plans	Vision Plans
<b>Who's Eligible</b>	Regular full-time or part-time employees scheduled to work at least 20 hours per week; Employees who meet the Patient Protection and Affordable Care Act ("ACA") definition of a full-time employee; Eligible dependents	Regular full-time or part-time employees scheduled to work at least 20 hours per week; Eligible dependents	Regular full-time or part-time employees scheduled to work at least 20 hours per week; Eligible dependents
<b>When Coverage Begins</b>	<b>New Hires and Their Dependents:</b> First day of the month following date of employment <b>Newly Eligible Dependents:</b> The date of the Qualified Status Change event if reported within 30 days of becoming eligible	<b>New Hires and Their Dependents:</b> First day of the month following date of employment <b>Newly Eligible Dependents:</b> The date of the Qualified Status Change event if reported within 30 days of becoming eligible	<b>New Hires and Their Dependents:</b> First day of the month following date of employment <b>Newly Eligible Dependents:</b> The date of the Qualified Status Change event if reported within 30 days of becoming eligible
<b>When to Enroll</b>	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment
<b>Who Pays Cost for Coverage</b>	Labcorp shares cost with employees; employees pay with before-tax dollars	Labcorp shares cost with employees; employees pay with before-tax dollars	Employees pay full cost with before-tax dollars
<b>Numbers &amp; Web Sites</b>	Labcorp Medical Plan:  Aetna <b>1-800-223-7331</b> <a href="http://aetna.com">http://aetna.com</a>  BCBS <b>1-833-466-0180</b> <a href="http://myhealthtoolkitnc.com">http://myhealthtoolkitnc.com</a> Plan LAG, select BlueCard PPO Network  Cigna <b>1-800-854-7315</b> <a href="http://www.mycigna.com">http://www.mycigna.com</a> Select Open Access Plus, OA Plus, Choice Fund OA Plus Network  UnitedHealthcare <b>1-800-791-9353</b>	Cigna <b>1-800-854-7315</b> <a href="http://www.mycigna.com">http://www.mycigna.com</a>	Vision Service Plan <b>1-800-877-7195</b> <a href="http://www.vsp.com">http://www.vsp.com</a>

	<a href="http://www.myuhc.com/groups/labcorp">http://www.myuhc.com/groups/labcorp</a> Select the Choice Plus Network  <i>Prescription Drug Coverage:</i> OptumRx <b>1-888-691-0169</b>  Optum RX Specialty Pharmacy <b>855-427-4682</b> <a href="http://www.optumrx.com">http://www.optumrx.com</a>		
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	Flexible Spending Accounts (FSAs)	No Charge Laboratory Testing (NCLT)	Disability (STD & LTD)
<b>Who's Eligible</b>	Regular full-time or part-time employees scheduled to work at least 20 hours per week	All employees	Regular full-time or part-time employees scheduled to work at least 20 hours per week
<b>When Coverage Begins</b>	First day of the month following date of employment	First day of work	First day of the month following date of employment*
<b>When to Enroll</b>	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment
<b>Who Pays Cost for Coverage</b>	Employees contribute before-tax dollars	Labcorp provides at no cost to employees and eligible dependents	Labcorp shares the cost with employees or employees can choose to pay 100% of the cost; employees use after-tax dollars
<b>Numbers &amp; Web Sites</b>	PeopleCare <b>1-888-800-4002</b> <a href="https://optumfinancial.com/labcorp">Optum Financial</a> <a href="https://optumfinancial.com/labcorp">https://optumfinancial.com/labcorp</a>	Benefits Central	New York Life Benefits Solutions <b>1-800-644-5567</b> <a href="http://myNYLGBS.com">http://myNYLGBS.com</a>

	Basic Life Insurance	Optional Life Insurance	Dependent Life Insurance
<b>Who's Eligible</b>	Regular full-time or part-time employees scheduled to work at least 20 hours per week	Regular full-time or part-time employees scheduled to work at least 20 hours per week	Spouse/Domestic Partner and eligible children
<b>When Coverage Begins</b>	First day of the month following date of employment*	First day of the month following date of employment, provided you enroll and meet any evidence of good health rules*	First day of the month following date of employment, provided you enroll and your dependent meets any evidence of good health rules*
<b>When to Enroll</b>	Automatic	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment
<b>Who Pays Cost for Coverage</b>	Labcorp pays full cost of coverage	Employees pay full cost with after-tax dollars	Employees pay full cost with after-tax dollars
<b>Numbers &amp; Web Sites</b>	Contact PeopleCare <b>1-888-800-4002</b> or visit the website <a href="http://www.prudential.com">www.prudential.com</a>	Contact PeopleCare <b>1-888-800-4002</b> or visit the website <a href="http://www.prudential.com">www.prudential.com</a>	Contact PeopleCare <b>1-888-800-4002</b> or visit the website <a href="http://www.prudential.com">www.prudential.com</a>

	Optional AD&D Insurance	Employee Stock Purchase Plan (ESPP)	TELUS Health EAP
<b>Who's Eligible</b>	Regular full-time or part-time employees scheduled to work at least 20 hours per week	Employees who reach age of majority in their resident state, who work more than 20 hours per week and who have completed six months of service as of the first day of the Offering Period	Regular full-time or part-time employees scheduled to work at least 20 hours per week and eligible dependents
<b>When Coverage Begins</b>	First day of the month following date of employment*	Any January 1 or July 1 after you meet age and service requirements	First day of work
<b>When To Enroll</b>	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment	Complete enrollment no later than 15 days before the start of an Offering Period	Automatic
<b>Who Pays Cost for Coverage</b>	Employees pay full cost with after-tax dollars	Employees pay full cost at discounted rate with after-tax dollars	Labcorp pays full cost of coverage
<b>Numbers and Web sites</b>	Contact PeopleCare <b>1-888-800-4002</b>	Fidelity Stock Plan Services <b>1-800-544-9354</b> <a href="http://www.netbenefits.fidelity.com/">http://www.netbenefits.fidelity.com/</a>	TELUS Health <b>1-888-319-0755</b> <a href="http://login.TELUS Health.com">http://login.TELUS Health.com</a>

Adoption Assistance Plan	
<b>Who's Eligible</b>	Regular full-time or part-time employees scheduled to work at least 20 hours per week
<b>When Coverage Begins</b>	First day of work
<b>When to Enroll</b>	Automatic
<b>Who Pays Cost for Coverage</b>	Labcorp pays full cost of coverage
<b>Numbers &amp; Web Sites</b>	TELUS Health <b>1-888-319-0755</b> <a href="http://login.TELUS Health.com">http://login.TELUS Health.com</a>
Legal Assistance Plan	
<b>Who's Eligible</b>	Regular full-time or part-time employees scheduled to work at least 20 hours per week
<b>When Coverage Begins</b>	First day of the month following date of employment*
<b>When to Enroll</b>	<b>New Hires:</b> Within 30 days of initial hire date <b>Current Employees:</b> Within 30 days of a Qualified Status Change or during Annual Benefits Enrollment
<b>Who Pays Cost for Coverage</b>	Employees pay full cost with after-tax dollars
<b>Numbers &amp; Web Sites</b>	MetLife Legal Plans, Inc <b>1-800-821-6400</b> <a href="http://www.info.legalplans.com/4480010">http://www.info.legalplans.com/4480010</a>
* Provided you are actively at work on that day; otherwise, benefits begin when you return to work on a regularly scheduled basis.	

# Overview Section

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This information is part of your Personal Choice Benefits Handbook for 2023, which constitutes the summary plan description (SPD) for the Labcorp health and welfare and retirement plans offered through the Labcorp Personal Choice Benefits Program subject to the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs certain employee benefit plans. The Handbook provides only a summary of the plans as in effect on January 1, 2023 for employees of Labcorp on or after January 1, 2023. In the event of any conflict between information contained in this Handbook and the official Plan documents, the official Plan documents govern.

This Handbook does not establish enforceable employee rights, contractual or otherwise, and does not establish an employment relationship enforceable by employees. The provisions of the Handbook do not constitute a contract and are subject to change at any time without notice (except as otherwise required by law). Nothing in this Handbook or any other publication from Labcorp shall interfere with or limit in any way the right of Labcorp to terminate any employee's employment without cause or notice at any time, confer upon any employee any right to continue employment with Labcorp, or change an employee's existing at-will employment status. You remain an employee at-will, which status may be changed only by an authorized Labcorp representative in writing.

For information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information, see An Overview of Personal Choice in this Handbook.

Labcorp reserves the right to change, suspend or terminate any benefits and any plan at any time. The information in this 2023 Handbook supersedes and replaces all prior summary plan descriptions, program summaries, communications, whether oral or written, or other information relating to the plans, benefits and programs. Separate summary plan descriptions describe the provisions of the Medical Plan applicable to other groups of employees.

## An Overview of Personal Choice

How much do you earn? At Labcorp, you take home more than your paycheck. You receive a Total Compensation package that includes not only your base pay, but benefits that provide medical coverage, income protection if you become disabled, life insurance and retirement savings.

Personal Choice provides optional benefits as well as some basic levels of benefit protection that Labcorp automatically provides for eligible employees at no cost to employees.

Other Medical Plan options may be available based on your geographic location. Please contact PeopleCare at 888-800-4002 for more details and for what Medical Plan options are available in your area.

## Who Is Eligible

### Employees

In general, you are eligible to participate in the Labcorp Personal Choice benefits program if you are a full-time or part-time employee who is regularly scheduled to work at least 20 hours each week. Any difference in the eligibility requirements for a particular benefit is described in the separate section of this Handbook for that benefit.

You will lose eligibility for most Labcorp benefits if you change status (for example, if you move to “casual” or “call-in” status) or if you leave Labcorp, even if you later return to Labcorp.

The Patient Protection and Affordable Care Act (“ACA”) requires employers to offer medical plan coverage to employees who qualify as full-time employees as defined by ACA. Full-time employees under ACA are those who work on average 30 or more hours per week, the monthly equivalent of which is 130 or more hours per month. Rules have been issued by government agencies that employers can use to determine which of its employees are full-time employees under ACA, including the development of a look back measurement method to determine full-time employee status for a prospective period of coverage. Employees who meet the ACA full-time employee definition will be notified and will be given the opportunity to elect medical coverage only.

### Dependents

When you enroll yourself in Labcorp benefit plans, you may also cover your eligible dependents for medical, no charge laboratory testing, dental, vision, dependent life insurance and AD&D insurance coverage. Eligible dependents include your:

- legal spouse,
- domestic partner,
- children up to the last day of the year in which they turn age 26 regardless of their student status, marital status, financial support provided by the employee, or residency, and
- adult disabled child.

Your “legal spouse” means your lawful opposite-sex spouse or lawful same-sex spouse. Your same-sex spouse is your legal spouse if you were married in the US, or a foreign jurisdiction that permits same-sex marriage, regardless of your current state of residence. If you are in a domestic partnership or civil union partnership that is not recognized as a marriage for State law purposes, your partner is not recognized as a spouse.

#### **To cover a same-sex or opposite-sex domestic partner, you must meet all the following requirements:**

- Be in an exclusive, committed relationship with your partner that is expected to last indefinitely,
- Be living in the same household as your partner,
- Be responsible for your partner's welfare (or vice versa) on a continuing basis,
- You and your partner must not be of an age or degree of relationship that would prohibit legal marriage,
- Neither you nor your partner may be married to anyone else, and
- Neither you nor your partner may have had a different domestic partner in the past 90 days (except in the case of death). The life insurance policy requires 12-months cohabitation to be eligible.

#### **Definition of Domestic Partner:**

Satisfies the requirements for being a domestic partner, registered domestic partner or party to civil union under the law of your jurisdiction of residence OR is a person of the same or opposite sex who satisfies ALL of the following:

- Is age 18 or older; and
- Is not related to you by blood or a degree of closeness that would prohibit marriage in the law of the jurisdiction in which you reside; and
- Is not married to another person under statutory or common law nor in a domestic partnership, registered domestic partnership or civil union with another person; and
- Has shared a single permanent residence with you for at least 12 consecutive months; and

- Is mentally competent to consent to contract; and
- Is financially interdependent with you

Children means:

- natural children,
- children for whom you or your spouse/domestic partner have legal custody or legal guardianship,
- legally adopted children, or
- stepchildren.

You may cover children up to the end of the year in which they reach the age of 26 who are lawfully placed with you while waiting to be legally adopted.

Unless otherwise specified in the plan documents, benefits for a dependent child continue until the last day of the year in which he or she reaches the Plan's age limit requirements.

## Adult Disabled Child

A child who is age 26 or older and is permanently and totally disabled will still be eligible for coverage if the following conditions are met:

- the child became permanently and totally disabled before age 26
- you or your spouse/domestic partner remain eligible for Labcorp benefits,
- you submit proof of your child's continued disability as requested, and
- you pay any required contributions.

You may be required to provide proof of dependent eligibility by providing, for example, tax returns, marriage certificate, birth certificate, court order, adoption papers, or certificate or affidavit of common law marriage. The plan administrator, in its sole discretion, will make the final determination as to whether a child qualifies as "permanently and totally disabled."

### WHEN YOU AND A BENEFITS ELIGIBLE DEPENDENT BOTH WORK FOR LABORATORY CORPORATION OF AMERICA HOLDINGS OR ONE OF ITS SUBSIDIARIES

Please keep in mind that the following limitations apply to your medical, dental, and vision coverage if you and your eligible dependent both work for the Company:

- If you and your spouse/domestic partner both work for the Company, you may not be covered as both an employee and as your spouse's/domestic partner's dependent.
- If a child is eligible for coverage by more than one employee, only one employee may cover the child.
- If you and your adult child both work for the Company, your adult child may not be covered as both an employee and as your dependent.

## When Coverage Begins

### For You

If you are a full-time or part-time employee regularly scheduled to work at least 20 hours each week, your coverage begins on the first day of the month following your date of employment, provided you have completed your enrollment within 30 days after you begin work. After your initial enrollment, you will have the opportunity to change your benefit plan coverage each year during the Annual Benefits Enrollment period or after a Qualified Status Change as defined below. If you are a part-time employee and you are transferred to a full-time employee status, your original date of hire will be used to determine whether or not you have satisfied the waiting period for benefits.

You are automatically eligible for the following benefits with no waiting period:

- TELUS Health Employee Assistance Program
- No Charge Laboratory Testing Benefit

Once eligible for benefits, you are automatically covered by the following benefit plans:

- Basic Life Insurance
- Business Travel Accident Insurance
- Employee Assistance Program
- Basic Disability Plan
- Adoption Assistance Program

If you do not complete your enrollment within 30 days of employment, you will have no benefit coverage for the benefits listed below until either (1) you experience a Qualified Status Change during the calendar year (See Changing Your Coverage During the Year) or (2) January 1 following your election to enroll in coverage made during Annual Benefits Enrollment which is normally held in the Fall:

- Medical (including prescription drug)
- Dental
- Vision
- Flexible Spending Accounts (health and dependent care)
- Optional Life
- Dependent Life
- Optional Accidental Death & Dismemberment
- Enhanced Long-term Disability
- Legal Assistance
- Voluntary Benefits

The Employee Stock Purchase Plan and 401(k) Plan are subject to different eligibility and participation rules.

### For Your Dependents

Your eligible dependents may become covered for medical, no charge laboratory testing, dental, vision, dependent life, or optional AD&D Insurance coverage at the same time as you, provided you complete your enrollment as described above.

## Enrolling For Coverage

If you are enrolling for the first time as a new employee or as a newly eligible employee, you must complete the enrollment process. It is very important that you complete this process.

Your enrollment also gives Labcorp permission to deduct your portion of the cost of coverage from your paychecks.

## Delayed Coverage

If you are absent from work on the date your Disability, Life Insurance, AD&D Insurance, and Legal Assistance Plan coverage are scheduled to begin, coverage will begin on the date you return to work on a regularly scheduled basis.

If an eligible dependent is confined at home, in a hospital or elsewhere, or is not performing normal daily activities on the date coverage is due to begin, Dependent Life and Optional AD&D Insurance for this dependent begins on the date the confinement ends or normal activities resume.

## Changing Your Coverage During the Year

It is important for you to know that once you have enrolled in medical, no charge laboratory testing, dental, vision, life insurance, AD&D, disability, legal assistance plan or FSA coverage, you may not add, drop or change the coverage for yourself or your dependents until either (1) the beginning of the next calendar year or (2) after you have had a Qualified Status Change as described below. The coverage changes you make must be consistent with the Qualified Status Change that occurs. If your election is requested within 30 days (60 days in the case of loss of coverage or eligibility for a state premium assistance subsidy under Medicaid or a state child health program), it will become effective as of the date of the Qualified Status Change. If you request a change in coverage within 30 days (or 60 days, if applicable) of the Qualified Status Change, Labcorp pays the cost of any coverage added from the date of the Qualified Status Change to the date your request is made. If you fail to request coverage changes within the 30 or 60 days permitted, you may not change your coverage until the next Annual Benefits Enrollment (or other Qualified Status Change, if earlier).

If you have a change of family or employment status that results in a loss of coverage (Qualified Status Change), you may change your coverage or add or drop one or more dependents following the Qualified Status Change.

A Qualified Status Change includes:

- You change your legal marital status, which includes marriage, death of your spouse, divorce, legal separation or annulment, or change in domestic partner status.
- Your dependents change due to birth, adoption, placement for adoption or death of the dependent.
- You decline coverage for yourself and/or a dependent in writing when originally offered because you have continuation coverage under a prior employer's plan, and the continuation coverage under the prior employer's plan ceases (either because the continuation coverage was COBRA coverage and the COBRA continuation period has ended, or because the continuation coverage was not COBRA coverage and you or your dependent lost eligibility for the coverage or the prior employer stopped contributing toward the coverage).
- Your spouse/domestic partner or your dependents commence or cease to meet the eligibility requirements under another employer's plan because of a change in employment status (such as a spouse's change from hourly to salaried employment, or from a covered position to a non-covered position).
- You, your spouse/domestic partner or your dependents terminate or commence employment.
- You, your spouse/domestic partner or a dependent reduce or increase hours of work.
- A dependent ceases to satisfy the requirements for coverage due to attainment of age.
- You, your spouse/domestic partner or your dependents move to a location outside of your current network.
- You, your spouse/domestic partner or your dependents become entitled to coverage under Part A or Part B of Medicare or Medicaid.

- You, your spouse/domestic partner or your dependents commence or return from an unpaid leave of absence such as Family and Medical Leave or military leave.
- You or your spouse/domestic partner receives a court order to provide coverage for your child.
- Your spouse/domestic partner or dependent is employed by an employer that allows a person to elect health benefits on a before-tax basis, and your spouse/domestic partner or dependent changes coverage under the other employer's plan during an annual benefits enrollment period or a permitted election change period that occurs during a calendar year.
- You enroll in a qualified health plan through a federal or state Marketplace during the Marketplace's annual enrollment period or during a special enrollment period available in the Marketplace
- You terminate employment and are rehired by Labcorp more than 31 days after your termination.
- You or your spouse/domestic partner or dependent experience a significant termination of medical, dental or vision coverage.
- Your spouse/domestic partner or dependent experiences a significant increase in the cost of their coverage.
- Your spouse/domestic partner or dependent starts or returns from a strike or lockout.

If you experience a Qualified Status Change, be sure to go online to the Benefits Enrollment System or call the PeopleCare Advocacy Center to report the change right away. You only have 30 days (60 days in the case of loss of coverage or eligibility for a state premium assistance subsidy under Medicaid or a state child health plan) from the date of your Qualified Status Change to make changes to your benefit coverages that are consistent with the Qualified Status Change. You may be required to submit supporting documentation to PeopleCare upon request. You can contact PeopleCare at **1-888-800-4002** Monday - Friday 8 a.m. to 8 p.m. ET.

No changes to your benefits will be permitted after 30 days (60 days in the case of loss of coverage or eligibility for a state premium assistance subsidy under Medicaid or a state child health plan) from the Qualified Status Change until the next Annual Benefits Enrollment.

## When Coverage Ends

The following describes when your and/or your dependent's benefit coverage ends:

- you transfer to an employment category that is not eligible to participate in a benefit plan,
- a plan is terminated,
- you cease to make required contributions,
- your spouse or domestic partner legally ceases to be your spouse or domestic partner, or
- you have been in a leave of absence status for a period of more than 6 months. Note: persons who have been in a leave of absence status due to a disability do not lose coverage under the Disability Plan.

If your employment ends for any reason, your benefits will end at midnight on the last day of the month during which you leave Labcorp.

Your STD coverage terminates if your employment terminates for any reason and your LTD coverage terminates if your employment terminates for any reason other than disability.

In general, coverage for your children ends when your coverage ends or at the end of the calendar year in which they reach age 26, whichever occurs first.

Coverage for you and your dependents will also end if you elect to cancel coverage during an Annual Benefits Enrollment event. Changes made during the Annual Benefits Enrollment event are effective the following January 1.

Coverage for the TELUS Health Employee Assistance Plan, including counseling sessions, is available to employees and eligible dependents for up to 90 days after the employee's termination of employment.

## Reinstatement

If you are rehired within 31 days after your employment terminates for any reason, your benefit coverages, including your before-tax elections, will be reinstated automatically. You will not have to satisfy the waiting period for any benefit plan and any claims incurred during your absence will be processed under the terms of the applicable plans.

## Continuation Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), loss of coverage resulting from certain “qualifying events” will result in continued eligibility for the Medical, Dental, Vision, No Charge Laboratory Testing, and Health Care Flexible Spending Account Plans if you elect and pay for the coverage as described in this section. Your spouse/domestic partner and children may have the right to continue their coverage even if you do not elect to continue your own coverage. This continued coverage also applies to children born to, or placed for adoption with, an employee during this continuation coverage. An individual who participates in COBRA is known as a qualified beneficiary.

You may elect COBRA continuation for yourself and/or your eligible dependents if your coverage ends due to:

1. your termination of employment with Labcorp (for reasons other than gross misconduct),
2. reduction in your work hours.

Your spouse, domestic partner or other dependent may elect COBRA continuation coverage if coverage ends due to:

1. your death,
2. your divorce or legal separation or your domestic partner ceases to be your domestic partner,
3. your dependent child no longer meeting the eligibility requirements for coverage,
4. your becoming entitled to Medicare (and you choose to drop Labcorp's coverage on your dependents),
5. your termination of employment with Labcorp (for reasons other than gross misconduct),
6. reduction in your work hours.

Your dependent child, including a child born to or placed for adoption with you during your COBRA continuation coverage, is also eligible for COBRA continuation coverage if coverage ends due to:

1. your dependent child no longer meets the eligibility requirements for coverage,
2. your divorce or legal separation or your domestic partner ceases to be your domestic partner,
3. your termination of employment with Labcorp (for reasons other than gross misconduct),
4. reduction in your work hours,
5. your death.

Qualified beneficiaries who elect COBRA continuation coverage are able to make changes to their health care coverage during the Annual Benefits Enrollment period.

## Electing COBRA Coverage

If any of the following events occur, the COBRA Administrator will notify you, your spouse/domestic partner and/or your covered dependents of the right to elect COBRA coverage:

- You terminate employment with Labcorp,
- Your hours are reduced so that you are no longer eligible for coverage under the Labcorp group health plans,
- You die.

It is your dependent's responsibility to notify the COBRA Administrator at **1-888-800-4002** within 60 days of any of the following events:

- You divorce or become legally separated,
- Your domestic partner ceases to be your domestic partner,
- Your adult dependent turns age 26, or
- Your child ceases to meet the definition of child under the Plan.

If the COBRA Administrator is not notified within 60 days of any of these events, any dependent who loses coverage because of any of these events will lose their right to elect COBRA coverage.

The COBRA Administrator will provide a notice describing COBRA coverage and the requirements to elect coverage.

## Length of Election Period

COBRA continuation coverage must be elected no later than 60 days from the date on the election notice or the date on which coverage is lost, whichever is later.

## Terms of Continuation Coverage

- If elected, COBRA continuation coverage is identical to the coverage provided to similarly situated employees.
- If your employment ends after Annual Benefits Enrollment, but before January 1, any elections you made to change your coverage during Annual Benefits Enrollment will be cancelled. You will be mailed a special enrollment package for COBRA continuation coverage that allows you to elect continuation of your current coverage through COBRA and to change your current enrollment for the next calendar year. If you are not enrolled for coverage when your employment ends, you will not be able to elect COBRA continuation coverage.

## Period of Coverage

Coverage generally cannot be continued beyond the earlier of the following dates:

- for you and your dependents, 18 months from the date you terminated employment or had a reduction in work hours that resulted in a loss of coverage, or
- for your dependents, 36 months from the date of your death, divorce or legal separation or domestic partner ceasing to be your domestic partner or, in the case of a dependent child, 36 months from the date your child no longer meets the eligibility requirements for coverage.

If a second qualifying event occurs while COBRA continuation coverage is in effect during the original 18-month continuation period that follows your termination of employment or reduction in hours, the continuation period for your dependent who is affected by the second qualifying event will be extended to 36 months from the date of the first qualifying event. For example, if you terminate employment (for a reason other than gross misconduct) on May 1, 2020, you and your dependents' original COBRA continuation period normally would end on November 1, 2021. However, if you die during the continuation period while your family was covered under COBRA continuation coverage, your family's COBRA continuation period would be extended so that they could continue their coverage to May 1, 2023.

If you die while an active employee, your eligible dependents will receive COBRA continuation coverage — at no cost for the first 6 months following your death — provided they were enrolled for coverage at the time of your death.

**Special Disability Rules.** If you or a covered dependent becomes disabled as determined by Social Security within 60 days following a qualifying event, you can request an extension in the continuation period from 18 to 29 months. This extension applies to you and all covered dependents. To obtain this extended coverage, you must notify the COBRA Administrator within 60 days of being classified as totally disabled under Social Security and within 18 months of the qualifying event.

If you receive this extended coverage, you must pay 102% of the full cost of the continuation coverage for the first 18 months. After 18 months, the required payments will increase from 102% to 150% of the full cost of coverage.

If you receive the extended coverage, you are required by law to notify the COBRA Administrator that you are no longer disabled within 30 days of any final determination made by Social Security. Once notified, your extended coverage will end as of the first month beginning more than 30 days after Social Security's determination.

## When Coverage Ends

COBRA continuation coverage will end if the covered individual:

- fails to pay the required monthly cost — other than the first premium — within 30 days of the due date,
- becomes covered under another group health plan after the date of your COBRA election —except if coverage under the new plan is limited because of a pre-existing condition exclusion, or
- becomes enrolled in Medicare Parts A and/or B after the date of your COBRA election.

Coverage will also end if Labcorp terminates all of its group health plans.

## Cost of Coverage

COBRA continuation coverage is provided at your or your dependent's expense. The cost to you or your dependents for this coverage is 102% of Labcorp's cost. However, in the case of a disabled individual whose 18-month continuation is extended to 29 months, the cost is 150% of Labcorp's cost during the extended 11-month period.

Your premiums are due on the first of each month. Your first premium payment is due within 45 days of the date you elect COBRA continuation coverage.

## How You Pay for Coverage

Your contributions for certain benefits are made on a before-tax basis. This means that your contributions are automatically deducted from your paycheck before Social Security (FICA), federal, and in some cases, before state and local taxes are withheld. As a result, you save money on taxes and, in effect, pay less for your coverage.

Here is a list of the before-tax and after-tax benefits available through the Personal Choice Benefits Program.

BEFORE-TAX BENEFITS	AFTER-TAX BENEFITS
<ul style="list-style-type: none"><li>• Medical Plan</li><li>• Dental Plan</li><li>• Vision Plan</li><li>• Flexible Spending Accounts</li></ul>	<ul style="list-style-type: none"><li>• Optional Life Insurance</li><li>• Dependent Life Insurance</li><li>• Optional AD&amp;D Insurance</li><li>• Disability Insurance</li><li>• Legal Assistance Plan</li><li>• Employee Stock Purchase Plan</li></ul>

Because your Social Security taxes are reduced, your Social Security benefits may also be reduced.

The value of certain benefits is considered imputed income, which means you pay taxes on the value of that coverage. You will have imputed income on the amount of your Labcorp-paid basic life insurance coverage in excess of \$50,000 or the entire amount of your Labcorp-paid basic life insurance coverage if you are one of the top 50 highly compensated officers of Labcorp.

For Federal tax purposes, if you are in a domestic partner or civil union relationship that is not recognized as a marriage under State or foreign law, you will be subject to imputed income on the value of medical, dental and vision coverage for your partner and/or his/her children. You may also be subject to imputed income for State tax purposes, depending on the law of the State in which you live. If you are in a lawful same sex marriage, you will not be subject to imputed income for Federal tax purposes. You may, however, be subject to imputed income on the value of the medical, dental and vision coverage provided to your partner and/or his/her children depending on the State tax laws of the State in which you live.

\*This example is based on the federal tax laws in effect on November 1, 2013. Any change in tax laws may impact the amount of annual tax savings reflected in this example.

## Coordination of Benefits (COB)

You or your family members may be covered by more than one health care plan, most likely because your spouse/domestic partner has medical, dental or vision coverage through his or her employer. Even so, you can't be covered twice for an expense that is covered by both group plans. The most you'll receive for any covered expense is what the more generous plan will pay. This process is called "coordination of benefits" (or "COB") and here's how it works.

One benefit plan is considered primary and the other plan is considered secondary. The primary plan pays claims first, and the secondary plan pays claims after the primary plan pays. In general, if a claim is for:

- *you* — the Labcorp plan is the primary plan and pays benefits first,
- *your working spouse/domestic partner* — his or her plan is primary, or
- *your child covered as a dependent under both plans* — the plan of the parent whose birthday (month and day) occurs earlier in the year is primary. In those states that have not enacted the "birthday rule," the father's plan is primary.

The plan that covers you or your dependent as an active employee pays for eligible expenses before any plan that covers you or your dependent as an inactive employee (retiree coverage, Medicare or COBRA).

When the primary plan responds, you should send a copy of that plan's explanation of benefits (EOB) statement and copies of all the itemized bills to the secondary plan for processing.

When a company has no coordination of benefits feature or has not adopted the birthday rule, that plan is always primary. If you are divorced or legally separated, special rules may apply. In these cases, please contact PeopleCare at **1-888-800-4002** for more information.

If you are considering obtaining coverage with another group health care plan, be sure you understand how Personal Choice health care plans coordinate benefits with other group health care coverage.

## Coordination of Benefits Through the Medical Plan

When you or a dependent is covered under two employer-sponsored medical plans and the Medical Plan through Labcorp is secondary, benefits are coordinated using maintenance of benefits. Under maintenance of benefits, the Medical Plan through Labcorp provides benefits only to make up the difference between what the other plan (the primary plan) paid and what the Medical Plan through Labcorp would have paid if it had been primary. This means that 100% coverage between the two plans is not provided. You are responsible for any charges not paid by either plan, including any amounts in excess of the Maximum Reimbursable amount.

The following example shows how benefits are paid under maintenance of benefits. The assumptions in the example are:

- the Labcorp Medical Plan is secondary,
- the other employer's medical plan is primary, and
- both plans pay benefits at 80% after the deductibles have been met.

When the Medical Plan through Labcorp is secondary, it will not pay any benefits until the primary plan has processed the claim.

LABCORP MEDICAL PLAN IN-NETWORK	
<b>Covered Expenses</b>	\$500
<b>Your Medical Plan through Labcorp— Benefit (\$500 x 80%)</b> (amount Labcorp Health Plan would pay if it is the primary plan)	\$400
<b>Primary Medical Plan Paid (\$500 x 80%)</b>	\$400
<b>Your Medical Plan through Labcorp Paid</b> (the difference in what your Medical Plan through Labcorp would have paid if it had been primary and what the other plan paid)	\$0
<b>Employee's Out-Of-Pocket Expense</b>	\$100

## When You Become Eligible for Medicare Due to Age

Medicare is the federal government's health insurance program for individuals age 65 or over. Once you reach age 65, even if you are still an active employee and covered by the Medical Plan, you may apply for Medicare. In such case, you may be covered by both the Medical Plan and Medicare. To the extent permitted by law, the Medical Plan will pay benefits second to Medicare. However, if you are age 65 or older and you are still an active employee, the general rule is that the Medical Plan may not consider what Medicare pays before the Medical Plan pays benefits. Here's how it works.

When you or your spouse/domestic partner has a medical bill covered by both the Medical Plan and Medicare, the Medical Plan provides the benefits to which you are entitled under the Medical Plan, if any, until its limits are reached. Medicare will then provide its benefits, but it may consider the amount paid by the Medical Plan when determining Medicare benefits.

## When You Become Eligible for Medicare Due to Disability

In addition to becoming eligible for Medicare when you reach age 65, you may also be eligible for Medicare benefits if you are under age 65 and disabled or have kidney failure. In such case, the coordination of your benefits will be different than the general rule for age-based eligibility for Medicare.

If you become disabled and qualify for Social Security disability benefits, you will become eligible for Medicare benefits after 24 months. In this event, the Labcorp Medical Plan will coordinate its benefits with those provided by Medicare in the following manner. Before the Medical Plan pays benefits, it first considers what Medicare pays—including Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).

Here's how it works.

When you or your spouse/domestic partner has a medical bill covered by both Medicare and the Medical Plan, Medicare pays its full benefits first. Then, the Medical Plan considers the same charge. In doing so, the Medical Plan first calculates your benefits without regard to Medicare. Then Medicare's payment is subtracted from the resulting amount.

## Coordination of Benefits Through the Labcorp Dental Plan

When the Labcorp Dental Plan is secondary, benefits are coordinated with benefit payments from other plans. This means that the total amount paid under all plans can be equal to, but not greater than, the total of expenses considered reasonable and customary.

Under the coordination of benefits provision, the primary plan provides benefits until its limits are reached. The secondary plan then provides benefits based on the amount not paid by the primary plan until the limits of the secondary plan are reached. If a third plan is involved, it then provides benefits. The total amount paid by all applicable plans cannot be greater than the total amount of the allowable expense.

When the Labcorp Dental Plan is secondary, it gives you credit for savings resulting from coordination. This credit is used to provide payments for allowable expenses that would not have been paid if it had been the only plan involved in the claim. Any credits arising from coordination of benefits do not carry over from one year to the next.

After all plans have paid benefits, you are responsible for any remaining charges, including any amounts more than the reasonable and customary amount.

The total amount paid by the Labcorp Dental Plan under the coordination process cannot be greater than what the Dental Plan would have paid if it had been primary. The Labcorp Dental Plan is always secondary to any medical plan providing dental benefits.

## Subrogation/Third-Party Liability

If you or a covered dependent (referred to in this section as a covered person) suffers an illness or injury involving a third party who may be liable ("responsible party"), either individually or through insurance (including, but not limited to, medical expense coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage), immediately upon paying or providing

any benefit under the Medical (including Prescription Drug), Dental or Vision Plan (each a Plan), the Plan will be subrogated to (stand in the place of) all rights to recovery of a covered person due to the injury, illness or condition of a covered person to the full extent of benefits provided by the Plan.

## Reimbursement

In addition, if a covered person receives any payment from any responsible party or insurance coverage as a result of an injury, illness or condition, the Plan has the right to recover from, and be reimbursed by, the covered person for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, from such payment, up to and including the full amount the covered person receives from any responsible party. By accepting benefits from the Plan (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider), the covered person agrees that any payment received by the covered person from any responsible party because of an injury, illness, or condition, will be held by the covered person as a constructive trustee for the Plan. Failure to hold such funds in trust will be deemed a breach of the covered person's fiduciary duty to the Plan.

## Plan's Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury, or condition for which the responsible party is liable. The lien will be imposed upon any recovery whether by settlement, judgment or otherwise, including from any insurance coverage, related to treatment for any illness, injury, or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the covered person, the covered person's representative or agent, the responsible party, the responsible party's insurer, representative or agent and/or any other source possessing funds representing the amount of benefits paid by the Plan.

By accepting benefits from the Plan (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider), the covered person acknowledges that the Plan's recovery rights are a priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered person's damages. The Plan is entitled to full reimbursement on a first-dollar basis from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered person in whole or in part for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered person to pursue the covered person's damage claim.

## All Settlements

All of the terms of this Subrogation/Third-Party Liability section apply to all settlements and judgments and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered person identifies the benefits the Plan provided or tries to allocate any portion of such settlement or judgment to the payment of expenses other than medical expenses. The Plan is entitled to recover from all settlements or judgments, even those designated as pain, suffering, non-economic damages and/or general damages only.

## Responsibility of Covered Person

The covered person must fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the claims administrator of the Plan within 30 days of the date when any notice is given to any party, including an insurance company or an attorney, of the covered person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the covered person. The covered person and any agents thereof must provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery obtained by the covered person, may result in the termination of coverage under the Plan for the covered person or the commencement of court proceedings against the covered person.

The covered person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce its terms. This includes, but is not limited to, refraining from making any settlement or

recovery attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The covered person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any responsible party. The Plan reserves the right to notify the responsible party and his/her agents (including, but not limited to, an insurance company and/or attorney) of the Plan's lien.

## Jurisdiction

By accepting benefits from the Plan (whether the payment of such benefits is made to the covered person or made on behalf of the covered person to any provider), the covered person agrees that any court proceeding with respect to this section may be brought in any court of competent jurisdiction that the Plan may elect. By accepting such benefits, the covered person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

## Qualified Medical Child Support Order

ERISA requires group health plans to comply with a Qualified Medical Child Support Order (QMCSO). A Qualified Medical Child Support Order:

- is any decree, judgment or order issued through an administrative process under state law or from a state court or administrative agency with jurisdiction over the child's support, including approval of a domestic relations settlement agreement, that
- recognizes the child as an alternate recipient for plan benefits, and
- provides for the child's support or health plan coverage, based on a state domestic relations law — including a community property law.

If you are currently enrolled in a Labcorp group health plan you can elect coverage for you and your child. You can enroll your dependent child only if you also enroll.

In general, to be qualified, the order must specify the employee's name and last known address (if any), each alternate recipient's name and address, a reasonable description of the coverage the child is entitled to, how long the child is entitled to coverage and each plan subject to the order.

The following rules apply to QMCSOs:

- children named in QMCSOs will be eligible for coverage as outlined under the plan (coverage not offered under the plan can't be mandated),
- a non-employee parent or state agency can enroll the child in the plan if the employee refuses to cooperate, and
- an employer can withhold contributions from the employee's salary to pay for the court-ordered coverage as compelled by state legislation.

The Labcorp group health plans have established written procedures to:

- determine an order's qualified status,
- administer benefits under a qualified order,
- provide prompt notification of the procedures to each person named in the order (at the address included in the order), and
- permit alternate recipients to name a representative to receive copies of any notices.

# HIPAA and Your Health Care Coverage

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The Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, requires employers like Labcorp who offer group health coverage to provide certain rights for employees, as described below.

## Pre-Existing Conditions

To comply with HIPAA, Labcorp's group health plans do not impose any pre-existing condition limitations. Your health care needs are covered based on the provisions of the plan you select, regardless of whether they existed before you became eligible for a Labcorp-sponsored health plan.

## Privacy Notice

HIPAA requires that you be provided a Privacy Notice regarding your Protected Health Information (PHI). PHI is information about you that can be used to identify you and that relates to your past, present or future physical or mental health, required care or the payment for that care.

In general, Labcorp, as plan sponsor, and each group health plan will use and disclose your PHI only for purposes of your treatment, payment and health care operations. The Notice lists other situations where Labcorp or a group health plan might disclose information, describes your rights and lets you know how you can access this information.

View the full text of the HIPAA Privacy Notices on Benefits Central or contact PeopleCare at **1-888-800-4002**.

## Medical Coverage

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The financial impact of a serious illness or injury could be devastating without adequate medical coverage. That's why Labcorp offers you comprehensive medical coverage to protect you from paying high medical expenses.

You may be able to choose from up to four network options, based on where you live. Please refer to the Summary Plan Description booklet available through Benefits Central for each plan listed below for coverage details.

- Labcorp Medical Plan – Healthy Premium (Aetna, BCBS, Cigna, UnitedHealthcare, UMR-Madison, WI Only)
- Labcorp Medical Plan – Healthy Standard (Aetna, BCBS, Cigna, UnitedHealthcare, UMR-Madison, WI Only)
- Labcorp Medical Plan – Healthy Value (Aetna, BCBS, Cigna, UnitedHealthcare, UMR-Madison, WI Only)

If you work at a Labcorp location in California and have elected coverage under the Kaiser Permanente Deductible HMO Plan, you should refer to the Evidence of Coverage issued to Labcorp by Kaiser Permanente for a description of your medical coverage. To the extent any information in this Handbook is inconsistent with the Evidence of Coverage from Kaiser Permanente, the Evidence of Coverage shall govern.

# Health Reimbursement Arrangement (HRA)

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A Health Reimbursement Arrangement (HRA) is an account the company funds that you can use to pay for qualified health care expenses.

When you enroll in the Labcorp Healthy Premium, Healthy Standard or Healthy Value Medical Plan you are provided access to an HRA Account. When you complete certain preventive services or wellness and disease management programs, the Company credits dollars to your HRA Account. You can use these dollars to pay for reimbursable medical and prescription drug expenses for yourself or your eligible enrolled dependents.

Individuals can save up to \$500 (\$1,000 for family coverage) on your out-of-pocket medical and prescription drug expenses by earning HRA Account dollars!

Keep in mind: you cannot contribute to the account; it is funded and owned exclusively by the company.

## Understanding the Basics

- You must be enrolled in the Labcorp Healthy Premium, Healthy Standard or Healthy Value Medical Plan.
- You may use HRA Account funds to pay for eligible medical expenses, including out-of-pocket costs to meet your deductible, copays and coinsurance.
- You can also contribute to a [Health Care Flexible Spending Account \(FSA\)](#), to give yourself even more pretax dollars to pay for out-of-pocket medical, dental and vision expenses.
- If you leave the company you will forfeit any remaining balance, unless you enroll in COBRA continuation of benefits.
- You are not able to make contributions to the HRA.

## Earning HRA Account Dollars

For the plan year, you may earn up to an annual maximum of \$500 in HRA Account dollars by completing online and telephonic Wellness Programs, and telephonic Disease Management Programs through OptumHealth, as well as specified healthy activities.

If your spouse/domestic partner is enrolled in the Labcorp Medical Plan, he or she also may earn up to \$500 in HRA Account dollars for the plan year. That's up to \$1,000 for your family HRA Account if you and your covered spouse/ domestic partner both earn the maximum amount of HRA Account dollars.

For more information about how to earn, see the [HRA Account Activities table](#).

## Using HRA Account Dollars

Your HRA Account funds can only be used for medical expenses, such as copays at your medical doctor's office, and for prescription drugs.

Once funds are in your HRA Account, you will receive a Spending Account Card that you can use for your reimbursable medical and prescription drug expenses. This is the same card you will receive if you enroll in the Health Care Flexible Spending Account. You will continue to use the card until you are no longer enrolled in the HRA Account or Health Care FSA.

## Unused HRA Account Dollars

Any unused dollars available in your HRA Account at the end of the year can be carried forward, subject to annual carryover limits of \$3,000 if only the employee is enrolled or \$6,000 if the employee covers one or more eligible dependents on their Labcorp Medical Plan.

# No Charge Laboratory Testing Benefit

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This information is part of your Personal Choice Benefits Handbook for 2023, which constitutes the summary plan description (SPD) for the Labcorp health and welfare and retirement plans offered through the Labcorp Personal Choice Benefits Program subject to the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs certain employee benefit plans. The Handbook provides only a summary of the plans as in effect on January 1, 2023 for employees of Labcorp on or after January 1, 2023. In the event of any conflict between information contained in this Handbook and the official Plan documents, the official Plan documents govern.

This Handbook does not establish enforceable employee rights, contractual or otherwise, and does not establish an employment relationship enforceable by employees. The provisions of the Handbook do not constitute a contract and are subject to change at any time without notice (except as otherwise required by law). Nothing in this Handbook or any other publication from Labcorp shall interfere with or limit in any way the right of Labcorp to terminate any employee's employment without cause or notice at any time, confer upon any employee any right to continue employment with Labcorp, or change an employee's existing at-will employment status. You remain an employee at-will, which status may be changed only by an authorized Labcorp representative in writing.

For information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information, see An Overview of Personal Choice in this Handbook.

Labcorp reserves the right to change, suspend or terminate any benefits and any plan at any time. The information in this 2023 Handbook supersedes and replaces all prior summary plan descriptions, program summaries, communications, whether oral or written, or other information relating to the plans, benefits, and programs.

## Who Is Eligible

Individuals who are eligible for the No Charge Laboratory Testing Benefit include:

- All employees, including casual employees, as of their date of hire
- Most dependents, including a spouse or domestic partner and eligible dependent children up to the plan year in which they turn age 26. (Eligible children include natural children, stepchildren, legally adopted children and children for whom you or your spouse/domestic partner have legal custody or legal guardianship.)

**Please note:** Eligible employees and dependents can use the No Charge Laboratory Testing Benefit even if they are not enrolled in one of Labcorp's group health plans.

## Who Is Not Eligible

Individuals who are not eligible for the No Charge Laboratory Testing Benefit include:

- Certain dependents, such as parents or grandchildren
- Contractors and employees working through a temporary staffing agency
- Employees who are members of a collective bargaining unit unless their bargaining agreement specifically provides a "no charge" laboratory testing benefit.
- Employee outside of the U.S.

## How to Enroll Your Dependents in the No Charge Laboratory Testing Benefit

You are automatically enrolled in the No Charge Laboratory Testing Benefit when you are hired. However, you must enroll your eligible dependents for the No Charge Laboratory Testing Benefit through the Benefits Enrollment System, even if you are not electing other Company-sponsored benefits. There are three times at which you can add eligible dependents to the No Charge Laboratory Testing Benefit:

- During Annual Enrollment
- During your 30-day enrollment window, if you are a new hire or newly eligible employee
- In connection with a Qualified Status Change during the year

## What Happens when you Leave the Company?

If you terminate or retire from Labcorp on January 1, 2023, or later you will be allowed to continue the No Charge Laboratory Testing Benefit for yourself or your enrolled dependents through the Consolidated Omnibus Budget Reconciliation Act (COBRA) for up to 18-months at no cost to you.

## What the Benefit Covers

The No Charge Laboratory Testing Benefit pays the full cost of most laboratory tests submitted to Labcorp for analysis on behalf of individuals eligible for this benefit. Tests not covered by this benefit include identity testing and any laboratory tests that are processed, sent out or “referenced” to a third party that is not a Labcorp facility. Tests requested through Labcorp OnDemand are also excluded from coverage through the No Charge Laboratory Testing Benefit.

## Confidentiality & Your Laboratory Results

To ensure your privacy, laboratory test results will be released only to the ordering physician or designee. If you set up a Labcorp Beacon Patient account, you can view your test results within a few days after they have been released to your physician or designee. Visit [patient.labcorp.com](https://patient.labcorp.com) to set up your account.

## How the No Charge Laboratory Testing Program Works if you ARE ENROLLED in the Labcorp Medical Plan

If a physician orders a laboratory test for you or your eligible dependent, you can receive coverage through the No Charge Laboratory Testing Benefit in one of two ways:

1. **Use a Labcorp Patient Service Center to have your specimen collected:** You may choose to have the laboratory test collected at a Labcorp Patient Service Center. Labcorp has a network of more than 1,700 Patient Service Centers nationally. You can use the Patient Service Center locator on [www.Labcorp.com](https://www.Labcorp.com) to locate a Patient Service Center near you and schedule an appointment to help reduce your wait time. ***Please note: some Patient Service Centers offer walk-up hours and appointment-only hours, so be sure to check prior to your visit.***

When you go to the Patient Service Center for the laboratory test, please bring the following information with you:

- Your medical insurance card
- Physician’s signed requisition form including:
  - Your name
  - Your relationship to the insured
  - Physician’s name

- Physician's address
- Physician's phone and fax number
- Labcorp account number- if applicable
- Labcorp Test number(s) or test name
- Diagnosis information (in narrative or ICD-10 code)

**Reminder:** If you have medical insurance through a Labcorp-sponsored plan or another insurance plan you **MUST** provide your insurance information before the laboratory test is performed. The claim for the test will be filed directly with your insurance plan.

2. **Use your physician's office or another medical facility to collect your specimen:** In some circumstances, you may need to have the laboratory specimen collected or procedure performed at the physician's office, a hospital, or other medical facility. If this situation occurs, please follow these procedures:
  - Provide the physician's office or other facility with your medical insurance card
  - Request that your physician send your laboratory test directly to Labcorp for analysis
  - Have the physician include a signed Labcorp requisition form including:
    - Your name
    - Your relationship to the insured
    - Physician's name
    - Physician's address
    - Physician's phone and fax number
    - Labcorp account number- if applicable
    - Labcorp Test number(s) or test name
    - Diagnosis information (in narrative or ICD-10 code)

**IMPORTANT:** Failure to provide the necessary information on the physician's requisition form may result in a delay in claims processing or coverage for the No Charge Laboratory Testing Benefit being denied.

## How the No Charge Laboratory Testing Benefit Works if you ARE NOT ENROLLED in the Labcorp Medical Plan

If you are not enrolled in the Labcorp Medical Plan, you may still receive coverage through the No Charge Laboratory Testing Benefit, even if you are enrolled in another medical plan or you do not have insurance through any other medical plan. Please refer to "Who is Eligible" above and follow the procedures outlined to ensure that your eligible dependents are enrolled in this benefit. If you request a test through Labcorp OnDemand, it will **not** be eligible for coverage. You will be responsible for any charges not covered through the No Charge Laboratory Testing Benefit.

## If You Receive a Bill from Labcorp

If at any time you receive a bill from Labcorp for an eligible laboratory test you would like to submit for the No Charge Laboratory Testing Benefit, be sure to:

- Verify your medical insurance has processed the claim. Remember, your claim must be filed with your medical insurance, if applicable, before the No Charge Laboratory Testing Benefit will be applied.
- Contact Labcorp Patient Billing if you receive a Labcorp bill showing any balance due after your medical insurance has processed the claim (or if you do not have medical insurance and your Labcorp bill shows a balance due.) You can contact Labcorp Patient Billing by:
  - **Computer:** go to [www.labcorp.com](http://www.labcorp.com) and click on "Patient Billing Center"
  - **Phone:** call the Patient Customer Service number listed on your Labcorp bill
  - **Mail:** return the Labcorp bill, the Explanation of Benefits (EOB) from your medical insurance and any other requested information to the address indicated on the Labcorp bill—keep a copy for your records.

# Prescription Drug Coverage

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Your Labcorp medical coverage includes certain prescription drug benefits. OptumRx administers the prescription drug program.

To learn more about your prescription drug coverage, refer to the information in this section of your Personal Choice Benefits Handbook. You will find additional information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information in the 2023 Overview Section of the Handbook.

If you work at a Labcorp location in California and have elected coverage under the Kaiser Permanente Deductible HMO Plan, you should refer to the Evidence of Coverage issued to Labcorp by Kaiser Permanente for a description of your prescription drug coverage. To the extent any information in this Handbook is inconsistent with the Evidence of Coverage from Kaiser Permanente, the Evidence of Coverage shall govern.

## A Word About Prescription Drugs

Some prescription drugs have generic drug alternatives. By law, both brand and generic drugs must meet the same standards for quality, purity and strength. This means generic drugs are just as effective as their brand name equivalents. Generic drugs are typically much less expensive, can dramatically reduce your out-of-pocket costs and provide a safe and effective alternative to brand name drugs.

When using a pharmacy that participates under OptumRx, the benefit is paid directly to the pharmacy or home delivery drug company. If, however, the pharmacy does not participate in the prescription drug program authorized by OptumRx, this benefit is paid directly to you. In this case, you must file a claim directly to OptumRx. Prescriptions purchased at a non-participating pharmacy will be reimbursed at a lower level. This level reflects any applicable copayment and prescription drug discount available through the participating pharmacies.

### Generic Drugs

Generic drugs contain the same active ingredients and are subject to the same FDA standards as their brand name counterparts. Generally, generic drugs cost less than brand drugs.

### Brand Drugs

Brand drugs carry the product name under which a drug is advertised and sold.

### Formulary Drugs

A formulary is a list of drugs that are covered under your prescription drug coverage. Formulary drugs have been found to be safe and effective in meeting the needs of both patients and their providers. Labcorp's Plan features a formulary to encourage you to use quality, affordable prescription medications that have proven to be effective. The drug formulary list is continually reviewed and updated based on input by expert doctors and pharmacists. If brand drugs are not part of the formulary, they are considered “**non-preferred**” and are typically more costly for you.

If you have questions about your prescription drug benefits or need to find out if your drug is on the

formulary, call OptumRx at **1-888-691-0169** or access the OptumRx Web site link through Benefits Central.

### **Premium Prescription Drug List**

Some medications are subject to exclusion if they are not listed on the OptumRx Premium Prescription Drug List (PDL); however, the therapeutic equivalent of these excluded prescription drugs will be covered. If you are currently taking a prescription impacted by the PDL, you will be notified by OptumRx. You can access the full PDL on Benefits Central.

## How You Pay for Your Prescriptions

The cost of your prescription medications depends on whether you:

- purchase generic, brand-name formulary or non-formulary drugs, and use a retail pharmacy or the **OptumRx Mail Service Pharmacy**.

### **Diabetic Supplies/Medications Copays Waived**

The pharmacy copay for certain diabetic supplies (i.e., lancets, test strips), will be waived or partially waived. The portion of the copay waiver for specific supplies is described below.

#### **DIABETIC INCENTIVE PROGRAM**

#### **COMMENTS**

##### **100% Copay Waived For Supplies**

Test strips, Insulin syringes/needles,  
Lancets, Alcohol swabs, Insulin pens,  
Insulin Pump supplies, Continuous  
Blood Glucose monitors

The supply will be eligible for the 100%  
copay waiver.

##### **50% Copay Waived For Diabetes Medications**

Oral Medications and Injectable  
Medications

Oral and Injectable Medications will be  
eligible for the 50% copay waiver.

##### **Refills By Mail Service**

For maintenance supplies, two fills  
per covered individual will be allowed  
at a retail pharmacy, then all refills  
must be submitted through mail  
service.

For Oral and Injectable Medications,  
two fills at a retail pharmacy will be  
eligible for the 50% copay waiver.

Maintenance supplies will not be eligible  
for the copay waiver if the member  
continues to use a retail pharmacy (that  
is not Walgreens) after the first two fills  
or switches from mail service back to  
retail for a covered supply.

Maintenance Oral and Injectable  
Medications will be eligible for the  
waiver for up to two fills at retail before  
mail service or using Walgreens is  
required.

## **Copay Reduction for Supplies**

To take advantage of the copay waiver for (maintenance) diabetic supplies, simply follow these guidelines:

- If you already use the **OptumRx Mail Service Pharmacy** or Walgreens for obtaining your diabetic supplies, you must continue to do so.
- If you are newly diagnosed, you can fill your first prescription for diabetic supplies at a retail pharmacy for \$0 copay/coinsurance. All subsequent refills must be ordered through the **OptumRx Mail Service Pharmacy** or Walgreens to receive coverage under the pharmacy plan.

## **Smoking Cessation and Weight Loss Medications Incentive**

Your prescription drug coverage includes smoking cessation and weight loss medications prescribed by your physician. If you need help to quit smoking or using tobacco products, these preventive medications will be available at \$0 cost- share. To qualify you need to:

- Be age 18 or older
- Get a prescription for these products from your doctor, even if the products are sold over the counter (OTC)
- Fill the prescription at a network pharmacy

Up to 180 days of treatment are covered at no-cost each year. Maximum daily dose quantity limits apply.

## **Mandatory Mail Service Pharmacy Program**

The mail service pharmacy program through **OptumRx** is mandatory for maintenance medications. Maintenance medications are those that a person takes for a long period of time, such as drugs used to treat high blood pressure, high cholesterol, diabetes or asthma. The advantage to you is that you will receive these medications at a long-term lower cost than if you had the prescriptions filled every 30 days, which is the typical time period for prescriptions from a retail pharmacy.

Here's what to do: The first time the doctor prescribes a maintenance medication, ask for two prescriptions, one to take to your local pharmacy for a 30-day supply so you can begin taking the medicine immediately, and one for up to a 90-day supply for you to mail to **OptumRx Mail Service Pharmacy or to take to a local Walgreens**. Any prescription sent to **OptumRx** and presented at a local Walgreens will be charged the full 90-day copayment (if applicable), so be sure to have the prescription written for up to a 90-day supply.

To get your maintenance prescriptions refilled through the **OptumRx Mail Service Pharmacy**, you can:

- Call the toll-free number: **1-888-691-0169**,
- Go to the Member Services section on the OptumRx Web site [www.optumrx.com](http://www.optumrx.com), or
- Mail your prescriptions to: OptumRx  
P.O. Box 2975  
Mission, KS 66201-1375

Standard delivery to your home is free, and your medications should arrive within 7 to 10 working days

from the day **OptumRx** receives your order. Be sure to request all home delivery medications at least three weeks before you need them, especially for new prescriptions.

You will be allowed to fill your maintenance medication (except for certain diabetic supplies) a maximum of two times within a 365-day period at your local pharmacy. Any additional refills must be filled through the OptumRx Mail Service Pharmacy or Walgreens to receive coverage. If you continue to fill your maintenance medications at your local retail pharmacy (other than Walgreens), you will pay 100% of the cost.

## **Generic Substitution Program**

Your prescription drug coverage has a generic substitution program that requires medications to be dispensed as generic drugs rather than brand drugs. Generic drugs will be dispensed by your pharmacist based upon their availability, state law and your physician's approval. Generic drugs usually are just as effective as brand name drugs because they are made from the same active ingredients as the brand name drugs. Like brand name drugs, they are manufactured according to standards and carry the approval of the Food and Drug Administration (FDA) for safety and effectiveness.

**Here's What to Do:** To ensure that you receive a generic drug whenever available, simply ask your physician to write the prescription for a generic drug before he or she writes out your prescription. Using generic drugs will save you money. Generic drugs cost less because there are reduced advertising expenses and lower overhead costs for drug companies who are manufacturing generic drugs.

If you choose to receive a brand name drug when a generic is available, you will be required to pay the brand copay and the difference in the ingredient cost of the two drugs.

If you have questions about generic substitutions, call the **OptumRx** toll-free Member Services Center at **1-888-691- 0169**, or go to the OptumRx Web site on Benefits Central.

## **Additional Prescription Drug Information**

**OptumRx** uses clinical guidelines to manage drugs that are expensive or have the potential to be used inappropriately.

## Quantity Limits

**Quantity Limits** — Maximum number of pills or units (i.e., injections or nasal spray bottles) covered by the Plan within 30 days. If prescribed, you may purchase more than the quantity limit allows, but you will be responsible for 100% of the cost of any amount over the quantity limit. Examples of drugs that may be subject to quantity limits are drugs prescribed for insomnia, migraine headaches and impotence. The chart below shows just a few examples of these drug categories and examples of drugs that may be prescribed which may be subject to quantity limits.

### Quantity Limits Examples

Drug Categories	Name Of Drug
Insomnia Drugs	Zolpidem, Doral
Anti-Migraine Drugs	Sumatriptan, Frovatriptan, Amerge
Impotence Drugs	Sildenafil, Tadalafil

## Step Therapy

**Step Therapy** — Coverage that is approved when other medications have been tried or if you have certain medical conditions that can only be treated by a specific prescription. Examples of medications managed through Step Therapy include, but are not limited to, Celebrex, Aciphex and Crestor. You must meet certain criteria before these medications are covered by the Plan.

**Example:** Your physician prescribes Crestor to treat high cholesterol. Before your prescription is approved, you must first try other drug options such as Lipitor or Simvastatin before Crestor will be approved.

If you have questions regarding a certain drug or about the Step Therapy process, call **OptumRx** at **1-888-691-0169**.

### Step Therapy Examples

Drug Categories	Name of Drug
Insomnia Agents	Edluar, Zolpimist
Gastrointestinal Agents	Protonix Pak, Aciphex
Topical Agents	Protopic, Pimecrolimus

## Prior Authorization

**Prior Authorization** — Medical necessity review is performed on certain medications. These reviews assure that medications are being dispensed for the appropriate reason. Your physician must provide a medical necessity for approval by **OptumRx**. Your physician may call **OptumRx** at **1-888-691-0169**. The chart below shows some drug categories and names of drugs that may require prior authorization.

### Prior Authorization Examples

Drug Categories	Name of Drug
Rheumatoid Arthritis	Enbrel, Humira, Kineret
Irritable Bowel Syndrome	Lotronex
Osteoporosis Drugs	Prolia

## Coverage of Preventive Care

Preventive care is covered at 100% for services which are recommended (with an “A” or “B” rating) by the *U.S. Preventive Services Task Force (USPSTF)*. This also includes some provisions covered under your prescription drug coverage, which includes medications such as fluorides, folic acid, immunizations and aspirins. Coverage is subject to certain age criteria as listed here:

- Aspirin 81mg: Prevent preeclampsia during pregnancy
- Fluoride: Oral dosages for children ages 6 months to 5 years
- Folic Acid: Oral dosages for women of childbearing age (18-45)
- Breast Cancer Prevention: For members who are at increased risk for breast cancer but have not had breast cancer, these preventive medications are available at \$0 cost-share. To qualify, a member must:
  - Be age 35 or older
  - Be at increased risk for the first occurrence of breast cancer - after risk assessment and counseling
  - Obtain prior authorization

Note that USPSTF recommendations for preventive care services are reviewed by the task force and may be subject to changes. As a result, the Plan may add, remove or modify the level of specific services under the preventive care benefit in order to comply with USPSTF recommendations and the law. For detailed information on the drug coverage in the Plan, contact PeopleCare **(888-800-4002)** or OptumRx **(888-691-0169)**.

## Specialty Pharmacy Program

**OptumRx** offers a Specialty Pharmacy Program to assist you in managing the cost and quality of services available to users of high-cost injectable medications. If you are using specialty medication to treat chronic illness, participation in this program is mandatory. The OptumRx Specialty Pharmacy has the experience to manage your condition and will work closely with you and your physician's office to arrange delivery for your specialty medications.

If you use specialty medications to treat such medical conditions as hepatitis C, cancer and multiple sclerosis, hemophilia or rheumatoid arthritis, you must obtain the medications through the **OptumRx Specialty Pharmacy Program** for specialty medications to be covered.

**Please note:** Specialty medications must be obtained through **OptumRx Specialty Pharmacy** to be covered.

**The benefits of using the OptumRx Specialty Pharmacy Program include:**

- Availability of educational materials as well as support or home instruction,
- Ancillary supplies such as syringes and needles at no additional charge,
- A higher level of coordination of care with your physician,
- Convenient access to a staff of pharmacists, nurses and care coordinators who are trained, specialists on the medications provided and the conditions being treated,
- Medication delivered promptly directly to your home, your doctor's office, or other specified location.

For the 30-day supply, you will pay the same member copay as if you used a retail pharmacy but will have the added convenience of the medication being shipped to you and timely coordination for future refills.

Once **OptumRx** receives your prescription information, a patient care coordinator will contact you to make all necessary arrangements.

If you have additional questions about the Specialty Pharmacy Program, call **OptumRx** at **1-855-427-4682**.

### Covered Expenses

OptumRx will consider the reasonable and customary charges made by a retail or mail service pharmacy for the cost of brand or generic prescription drugs, and the charges to dispense them, as covered expenses. The Plan will cover prescription drugs if they are obtained with a doctor's written prescription. The Plan will not cover over the counter items, with the exception of injectable insulin and medically required diabetic supplies, the insurer will only cover prescription drugs if they are obtained with a doctor's written prescription.

## Exclusions

Your prescription drug coverage does not pay for any prescription drug expenses incurred by a covered person which are not medically necessary, or which are above reasonable and customary charges. In addition, your prescription drug coverage does not pay for any:

- Charges incurred by a covered person before coverage is effective or after coverage ends.
- Drugs or medicines that may be obtained without a doctor's prescription. **OptumRx**, however, will pay for injectable insulin purchased at a doctor's direction.
- Prescription drugs which are provided to you free of charge from local, state or federal programs.
- Immunization agents, biological serum, whole blood or blood plasma or the charges to administer these items.
- Charges made to administer a prescription drug or insulin to you.
- Drugs or medicines to be taken by or administered to you while confined in: (a) a hospital; (b) an alcohol or drug treatment center; (c) a skilled nursing facility; or (d) any similar institution. These charges may be covered through Aetna, BCBS, Cigna or UHC. See the Medical SPDs for more information.
- Charges which exceed the frequency, quantity supply limits, dispensing limits or maximum benefits.
- Refills which exceed the number prescribed by a doctor, or any prescription filled more than one year after the date the prescription is written.
- Charges for drugs for which you failed to obtain a required Prior Authorization from **OptumRx**.
- Experimental drugs and those that are labeled: "Caution - limited by federal law to investigational use"; such drugs are not covered, even though a charge may be made to the patient. This does not apply to those drugs recognized under federal law as being medically appropriate for the specific type of treatment of an illness.
- Drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, etc., unless you obtain Prior Authorization from **OptumRx**.
- Drugs used for hair growth.
- Non-prescription antihistamines, cough or cold products.
- Maintenance drugs obtained through a retail pharmacy (other than Walgreens) after the second retail fill within a 365-day period. Two retail fills within a 365-day period per each maintenance drug (except for certain diabetic supplies which may be obtained only one time at a retail pharmacy) are permitted.
- Drugs used for fertility purposes, unless you obtain Prior Authorization from **OptumRx**. Fertility drugs are limited to a seven-month lifetime maximum.
- Charges for Allergy Serum and immunizations. These charges may be covered through Cigna or UHC. See the Medical Section of this Handbook for more information.
- The Plan specifically excludes a variety of compound medications which may change, at any time, without notice to you. The compound drug selection exclusion criteria are as follows: Bulk chemicals for vitamins and supplements typically available over the counter; Products for cosmetic uses; Medications used in compounding topical formulations when the medication is not approved by the Food and Drug Administration for this form of administration.

## Dental Coverage

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Visiting your dentist regularly is one of the best ways to prevent serious and costly dental problems. The Labcorp Dental Plan (referred to in this section as the “Dental Plan” or “Plan”) covers most preventive and diagnostic services in full and provides comprehensive coverage for a wide variety of other dental services. Please refer to the Summary Plan Description on Benefits Central for each plan listed below for more details.

- Labcorp Dental PPO
- Labcorp Dental HMO

# Vision Coverage

Vision care is an important part of any comprehensive health care program. Of course, vision care is more than just a change in an eyeglass prescription — it's also regular checkups that alert you to vision problems that can become serious if left untreated. Labcorp Vision Plan coverage provides benefits for eye examinations, frames/lenses and contact lenses up to certain limits.

Through the Labcorp Vision Plan - (referred to in this section as the "Vision Plan" or "Plan"), you have access to the largest eye doctor network in the U.S. You also have the freedom to choose to receive vision care and materials provided through a non-network provider.

To learn more about your vision coverage, refer to the information in this section of your Personal Choice Benefits Handbook. You will find additional information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information in the Overview Section of the Handbook.

## Quick Reference Guide

Use this "Quick Reference Guide" to find out — at a glance — what type of coverage the Labcorp Vision Plan provides. Then refer to the rest of this section of your Personal Choice Benefits Handbook for more information about this Plan.

VISION STANDARD PLAN FEATURE	BENEFIT LEVELS	
	In-Network	Out-of-Network
<b>Annual Eye Exam</b> (Once every calendar year)	\$20 copayment	\$20 copayment and balance due after the Plan pays up to \$47
<b>Lenses</b> (Basic cost of single vision, bifocal, trifocal, progressive, every calendar year)	\$0 copayment for eye glass lenses or frames	Balance due after the Plan pays up to: Single Vision: \$48 Bifocal: \$69 Trifocal: \$85 Lenticular: \$125 Progressive: \$69
<b>Frames</b> (Every other year)	\$20 copayment and balance due after the Plan pays up to \$120	Balance due after the Plan pays up to \$45
<b>Contact Lenses, Medically Necessary</b> (Every calendar year; in lieu of lenses and frames)	Covered in full	Balance due after the Plan pays up to \$210
<b>Contact Lenses, Elective</b> (Every calendar year; in lieu of lenses and frames)	Balance due after the Plan pays up to \$150	Balance due after the Plan pays up to \$105
VISION PREMIUM PLAN FEATURE	BENEFIT LEVELS	
	In-Network	Out-of-Network
<b>Annual Eye Exam</b> (Once every calendar year)	Covered in Full	Balance due after the Plan pays up to \$52

<b>Lenses</b> (Basic cost of single vision, bifocal, trifocal, progressive, every calendar year)	Covered in Full	Balance due after the Plan pays up to: Single Vision: Up to \$55 Bifocal: Up to \$75 Trifocal: Up to \$95 Lenticular: Up to \$125 Progressive: \$75
<b>Frames</b> (Every calendar year)	Balance due after the Plan pays up to \$180	Balance due after the Plan pays up to \$70
<b>Contact Lenses, Medically Necessary</b> (Every calendar year; in lieu of lenses and frames)	Covered in Full	Balance due after the Plan pays up to \$210
<b>Contact Lenses, Elective</b> (Every calendar year; in lieu of lenses and frames)	Balance due after the Plan pays up to \$180	Balance due after the Plan pays up to \$105

If you have any questions about the Vision Plan's benefits, limitations, or exclusions, call Vision Service Plan (VSP) Customer Service at **1-800-877-7195**.

## A Closer Look At How the Vision Plan Works

The Labcorp Vision Plan is insured by Ameritas Life Insurance and administered by Vision Service Plan (VSP). VSP's customer service number is **1-800-877-7195**.

Keep in mind that you can use the Health Care Flexible Spending Account to reimburse yourself for covered vision expenses above Plan maximums.

Visit VSP at [www.vsp.com](http://www.vsp.com) for general information about your Labcorp Vision Plan benefits.

### Plan Features

- You can locate a network provider by calling VSP or on the VSP Web site.
- You can also use non-network providers.
- Using network providers, however, results in a higher level of benefits and no claim forms to file.

## How to Access Vision Plan Benefits

### When Using a Network Provider:

1. You can locate a participating provider by visiting the Web site at [www.vsp.com](http://www.vsp.com) or by calling VSP at **1-800-877-7195**.
2. Make an appointment and identify yourself as a VSP member.
3. When services are complete, pay the required copayment. You have no claim forms to file; your provider will file claims with VSP.

### When Using an Out-of-Network Provider:

1. Make an appointment.
2. Pay the full amount for services.
3. Obtain an itemized receipt, including your name, mailing address, Social Security number and the patient's name, and send copies of this documentation to VSP for reimbursement:  
Vision Service Plan  
PO Box 385018  
Birmingham, AL 35238-5018

4. Please note that claims for reimbursement must be filed within six months of the date of service. Reimbursements are made directly to you, not the provider.

## Other Important Information

### Lenses and Frames

VSP covers a wide selection of frames, but not all frames will be covered in full. If you select a frame that exceeds the Plan's allowance, these additional charges are administered at VSP's controlled costs. VSP also has controlled costs for cosmetic options, which are generally less than usual and customary fees. In addition, VSP provides a 20% discount on non-covered pairs of prescription glasses.

After the annual copayment, the Plan provides a benefit for the cost of eyeglass lenses OR medically necessary contact lenses once every calendar year. You cannot receive coverage for lenses AND contact lenses in the same calendar year.

### Elective Contact Lenses

If you enroll in the Standard Vision Plan and purchase contacts, you will be eligible for complete eyeglasses (frames and lenses) in 2 years. If you enroll in the Premium Vision Plan and utilize the contact benefit, you will be eligible for benefit reimbursement on frames & lenses the following calendar year.

VSP includes a 15% discount on average off a participating doctor's fees when you purchase prescription contact lenses. Materials are provided at usual and customary fees. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses.

### Medically Necessary Contact Lenses

Medically necessary contact lenses are covered in full when prescribed by a participating doctor for one of the following conditions:

- following cataract surgery,
- to correct extreme vision problems that cannot be corrected with spectacle lenses,
- with certain conditions of anisometropia, or
- with certain conditions of keratoconus.

Your participating provider must receive approval from VSP before prescribing medically necessary contact lenses.

## What the Labcorp Vision Plan Covers

The Labcorp Vision Plan covers the following services and supplies:

- vision exams, including:
  - external exam of the eye and adnexa
  - ophthalmoscopic exam
  - determination of refractive status
  - binocular balance
  - tonometry test for glaucoma
  - gross visual field when necessary
  - summary finding
  - prescribing of lenses
- services provided by licensed doctors of medicine, including specialists in ophthalmology and licensed doctors of optometry, and
- suppliers such as opticians and retail optical firms licensed to make, fit, supply and adjust eyeglasses according to prescriptions written by licensed providers.

## What the Labcorp Vision Plan Does Not Cover

The following services and materials are not covered through the Labcorp Vision Plan:

- orthoptics or vision training and any associated supplemental testing,
- plano lenses (non-prescription),
- two pair of glasses in lieu of bifocals,
- lenses and frames furnished under this program that are lost or broken (except at the normal intervals when services are otherwise available),
- medical or surgical treatment of the eyes,
- corrective vision services, treatments and materials of an experimental nature,
- vision exams more than once in a calendar year,
- prescribed lenses more than once in a calendar year,
- exams performed or frames or lenses ordered after your coverage ends, unless coverage is continued through an extension of benefits,
- sub-normal vision aids,
- non-prescription lenses or non-prescription sunglasses,
- any eye exam or corrective eyewear required by an employer,
- any service or supply not specifically covered by the Plan,
- diagnostic services such as X-rays, pathological tests and lab tests,
- costs of premiums insuring against losses of lenses or frames,
- job-related injuries or occupational diseases,
- services covered by another group plan, expenses incurred before or after you or any eligible dependents were covered by the Plan,
- cosmetic lenses, and
- coating or laminating of the lens or lenses.

Be sure to call VSP for additional information about the Plan's limitations.

# Flexible Spending Accounts

Labcorp gives you the opportunity to enroll in the Health Care Flexible Spending Account and/or the Dependent Care Flexible Spending Account as a newly eligible employee or each year during Annual Benefits Enrollment. These accounts give you ways to pay for certain eligible health care and dependent care expenses using your before-tax pay. Your decision to participate in either or both accounts is based on your needs and personal situation. It's important that you understand the advantages and limitations of Flexible Spending Accounts (FSAs) before you decide whether or not to participate.

To learn more about the FSA Plan, refer to the information in this section of your Personal Choice Benefits Handbook. You will find additional information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information in the 2023 Overview Section of the Handbook.

## Quick Reference Guide

Based on your personal needs, you have the option to participate in either or both Flexible Spending Accounts (FSAs):

- Health Care Flexible Spending Account, and/or
- Dependent Care Flexible Spending Account.

Be sure you learn as much as possible about these accounts before you enroll. This will help you set aside an amount of before-tax pay you feel certain you will spend on health care or dependent care expenses during the year.

STEPS TO FOLLOW	ABOUT THE PLANS
<b>Before Enrollment</b> (decide in which FSA(s) to enroll)	Health Care FSA (limits: a minimum contribution of \$120 up to a maximum of \$2,850 per calendar year)  Dependent Care FSA (limits: a minimum contribution of \$120 up to a maximum of \$5,000 per calendar year)
<b>During Enrollment</b>	Estimate out-of-pocket expenses (not covered by a health plan) for prescription drug copays and coinsurance, dental and vision and unreimbursed medical expenses. Calculate your estimated dependent care expenses using the guidelines in this section
<b>During the Year</b>	Before-tax contributions from your pay go into your account(s): <b>Health Care FSA:</b> Use your Spending Account Card to pay for eligible health care expenses  <b>Dependent Care FSA:</b> Use tax-free reimbursements from your account to pay for eligible dependent care expenses
<b>At Year-End</b>	All claims for reimbursement for eligible health care expenses for a calendar year plus the 2 ½ month grace period thereafter — including all supporting documentation — must be postmarked no later than June 15 of the following year.  All claims for reimbursement for eligible dependent care expenses for a calendar year must be postmarked by March 31 of the following year “Use it or lose it” — You lose any money you don't claim in your account(s) after the deadline for filing reimbursement requests

## Your Flexible Spending Account (FSA) Contributions

When you establish a Health Care and/or a Dependent Care FSA, you choose the annual amount you want to contribute, up to certain limits. This amount is deducted from your paycheck in equal installments before federal, state (except in New Jersey and for dependent care expenses in Pennsylvania), most local income and Social Security taxes are withheld.

You can enroll in an FSA during Annual Benefits Enrollment or as a new hire or newly eligible employee. If you are enrolled in an FSA and experience a “change in family or employment status” (Qualified Status Change), you can change your FSA election during the year if the change is because of and consistent with the Qualified Status Change. See “Overview Changing Your Coverage During the Year.”

If you are rehired within 31 days of termination, your FSA elections will be reinstated automatically. If you are rehired more than 31 days following your termination but during the same plan year, you will be able to make new elections for the remainder of the plan year in which you are rehired.

Because you don't pay Social Security taxes on your contributions, your FSA contributions may reduce your wages reported for Social Security purposes. The effect on your future Social Security benefit at disability or retirement is usually very small.

### The Before-Tax Advantage

Making before-tax contributions through automatic payroll deductions lowers the amount of current income taxes and Social Security taxes that you would otherwise be required to pay. That's because the tax withheld from your pay will be based on your pay after your contributions to your FSAs rather than on your total pay. See “Overview; How You Pay for Coverage.”

## A Closer Look At How the Flexible Spending Accounts Work

You can set up two separate accounts — one for eligible health care expenses and one for eligible dependent care expenses. These are two separate accounts for two separate purposes. The amounts credited to one account can't be used to satisfy expenses in the other account. You can participate in either of these accounts or both — or none at all — depending on your needs.

Flexible Spending Accounts reimburse you for eligible expenses with before-tax dollars. If you enroll in the Health Care FSA you will receive an Optum Financial Spending Account Card which you can use to pay for eligible health care expenses. The Optum Financial Spending Account Card enables you to pay for eligible health care expenses with a simple swipe of the card wherever the Visa® brand mark is displayed. The Dependent Care FSA still requires that you go through the claim form reimbursement process. After you have an eligible expense, you submit a claim for reimbursement. Your eligible expense will be reimbursed from your available Dependent Care FSA account balance. If your Dependent Care FSA account balance is not sufficient to reimburse the entire amount claimed, you will be reimbursed any remaining amount when your Dependent Care FSA account has a balance available. The reimbursements you receive are tax-free.

It's important for you to understand how to use the Optum Financial Spending Account Card and how to file your Dependent Care FSA claims. See the section on how to file an FSA claim below.

## Health Care Flexible Spending Account

### Contribution Limits

You may contribute up to \$2,850 per year as a before-tax contribution to your Health Care FSA. The minimum amount you can contribute is \$120 per year. You can request reimbursement from your Health Care FSA on January 1 or the effective date of your coverage, if later. On that date the full amount you elected to contribute is available.

## Eligible Dependents

In general, an eligible dependent under the Health Care FSA is anyone you are legally able to claim as a dependent on your federal income tax return. This includes your immediate family members, a close relative or other person whose primary residence is your home and for whom you provide over 50% support. In most cases, a domestic partner is not considered an eligible tax dependent and therefore is not eligible for purposes of the Health Care FSA.

Remember, the definition of dependent under the Health Care FSA is different from other plans in this Personal Choice Benefits Handbook.

## Eligible Health Care Expenses

If you enroll in the Health Care FSA, you can use your Optum Financial Spending Account Card to pay for certain eligible health care expenses. Or, if necessary, you can submit a Reimbursement Request form to be reimbursed for eligible expenses that you or your dependents incur during the calendar year (plus the 2½ month grace period) in which you participate in the Plan. Certain items such as over-the-counter medications cannot be purchased using your Optum Financial Spending Account Card unless you have a doctor's prescription. However, you can still use your Optum Financial Spending Account Card to purchase non-drug over-the-counter items such as bandages, contact lens solution and thermometers. To be eligible, expenses:

- cannot have been reimbursed in full by the Labcorp medical, no charge laboratory testing, dental or vision plans or any other insurance policies that cover you or your dependents, and
- in general, must be considered deductible medical care expenses for income tax purposes under Section 213(d) of the Internal Revenue Code.

Examples of eligible health care expenses — to the extent not covered by another plan — include:

- charges above coverage maximums or reasonable and customary limits,
- contact lenses, solutions and other supplies,
- over-the-counter medications (e.g., medicines for allergies and colds, pain relievers, antacids, lactaid for lactose intolerance) as long as you have a valid prescription from your doctor for these medications,
- copayments and deductibles not covered by medical, dental or vision insurance,
- hearing aids,
- orthodontia (restrictions apply, please contact the FSA Claims Administrator for details),
- Lasik eye surgery,
- smoking cessation programs (even if not prescribed by a physician), and
- nicotine patches if prescribed by a physician.

For a complete list of eligible health care expenses, ask for Publication 502 from your local IRS office or on the IRS website at [www.irs.gov](http://www.irs.gov).

## Coordination of Health Care FSA and the Health Reimbursement Account

If you are enrolled in Labcorp medical coverage with a Health Reimbursement Account, it is important to understand what expenses can be paid from each account. The chart below describes which expenses can be paid from each account:

HEALTH CARE FSA ELIGIBLE EXPENSES	HEALTH REIMBURSEMENT ACCOUNT ELIGIBLE EXPENSES
<ul style="list-style-type: none"><li>• Medical - only if the Health Reimbursement Arrangement (HRA) Account balance is \$0</li><li>• Prescription Drugs - only if the HRA Account balance is \$0</li><li>• Over-The-Counter Medications prescribed by a physician</li><li>• Dental</li><li>• Vision</li></ul>	<ul style="list-style-type: none"><li>• Medical</li><li>• Prescription Drugs</li></ul>

If you have questions about a particular expense, you should contact Optum Financial at the numbers below.

If you have both a HRA Account and a Health Care FSA, your medical and prescription drug expenses not covered under the Labcorp Medical Plan will be reimbursed first from your a HRA Account. This applies to both card transactions and any paper claims submitted. Once your a HRA Account balance is zero, medical and prescription drug expenses not covered under the Labcorp Medical Plan will be reimbursed from your Health Care FSA. During the first 2½ months of each calendar year (grace period), medical and prescription drug expenses continue to be reimbursed from your HRA Account and then the remainder of your Health Care FSA balance. Dental and vision expenses not covered under the Labcorp Medical, Dental and Vision Plans are always reimbursed only from your Health Care FSA.

## The Optum Financial Spending Account Card

When you enroll in the Health Care Flexible Spending Account you will automatically receive a Optum Financial Spending Account Card from the claims administrator. The card enables you to pay eligible health care expenses with a simple swipe of the card. Use the card when you incur an eligible expense, and the money will be automatically deducted from your Health Care FSA. In most cases, you won't need to file a paper claim. It is always a good idea to keep your Optum Financial Spending Account Card receipts in case the claims administrator needs to validate your expenses in order to comply with the Internal Revenue Service (IRS) regulations that govern the Health Care FSA.

When using your Optum Financial Spending Account Card, here are several things you should keep in mind:

- Your Optum Financial Spending Account Card is accepted at pharmacies, dental offices, vision providers, physician offices and hospitals that display the Visa® brand mark. When making a payment for eligible health care expenses, you should select "credit" when prompted. You can also use the Optum Financial Spending Account Card to purchase eligible mail-order items, such as prescription medications, by simply entering your card number online or on the form as you would a credit card number.
- If a provider or facility does not accept the Optum Financial Spending Account Card, you will need to pay for the expense out of your pocket, and submit the claim form to Optum Financial for reimbursement. You will receive your reimbursement check from Optum Financial within two to three weeks from the date your Request for Reimbursement form is received.
- You can only use your Optum Financial Spending Account Card to pay for health care expenses that are considered eligible by the IRS as discussed above in the section entitled "Eligible Health Care Expenses." If you purchase ineligible items at the same time you pay for eligible expenses (such as buying shampoo and gum while you are paying for a prescription at a pharmacy), you must pay for the ineligible items separately. If you purchase both eligible and ineligible items using your Optum Financial Spending Account Card, you will be required to submit receipts to Optum Financial for the transactions.
- If the amount of your health care expense is greater than your Health Care FSA balance, the transaction will be denied. If you know how much is left in your Health Care FSA, ask the merchant to charge the remaining amount on your Optum Financial Spending Account Card and offer to pay the balance owed on the transaction with another form of payment. You can confirm the remaining balance of your FSA by calling the PeopleCare Advocacy Center number printed on the back of your Optum Financial Spending Account Card.
- You cannot use your Optum Financial Spending Account Card to make payments from your Dependent Care FSA.
- You cannot use your W Optum Financial Spending Account Card to withdraw cash from an ATM.
- If you have both the Health Care FSA and the Health Reimbursement Account (HRA) and you are seeking services for an eligible dependent who is not covered under the Labcorp Medical Plan, you will not be able to use the Optum Financial Spending Account Card at the point of sale. You will need to submit a paper claim for reimbursement of eligible expenses.

If you are enrolled in the Labcorp Medical Plan, it is important to remember that you cannot use the Optum Financial Spending Account Card for eligible medical and prescription drug expenses until your Health Reimbursement Account balance has reached zero.

## Ineligible Health Care Expenses

The IRS has a list of health care expenses it does not consider deductible for income tax purposes. Here is a partial list of ineligible health care expenses:

- accident and other health care and dental insurance premiums paid on a pre-tax basis,
- athletic club memberships, spas and non-prescribed weight loss plans,
- expenses reimbursed by another insurance or spending account plan,
- expenses not qualified by the IRS,
- expenses claimed as deductions on a federal tax return,
- expenses incurred before you were, or after you ceased to be, a spending account participant,
- cosmetic surgery and related expenses (that improve appearances but do not prevent or treat illness or disease),
- hair loss treatments or transplants,
- funeral or burial expenses, and
- teeth whitening or bleaching.

Keep in mind that eligible expenses that are paid from your Health Reimbursement Account cannot also be submitted for reimbursement through your Health Care FSA.

If you are uncertain as to whether a health care expense qualifies for reimbursement under the Health Care FSA, you may call the PeopleCare Advocacy Center at **1-888-800-4002**.

## Dependent Care Flexible Spending Account

### Contribution Limits

In the Dependent Care FSA, you may contribute up to \$5,000 per year. The minimum amount you may contribute per year is \$120. The \$5,000 annual maximum applies to all contributions made by you and your spouse to a dependent care flexible spending account through Labcorp and any other employer.

In the case of a divorce, only one parent can contribute to a Dependent Care FSA. If you are considered the custodial parent, you can contribute up to \$5,000 to the Dependent Care FSA.

### Contribution Amounts If You Are Married

IF THIS IS YOUR SITUATION . . .	THEN YOUR MAXIMUM ANNUAL CONTRIBUTION IS:
<b>Your spouse also participates in a Dependent Care Flexible Spending Account ...</b>	Up to \$5,000 combined for both accounts or, if lower, the amount the lower-paid spouse earns
<b>You file separate federal income tax returns ...</b>	Up to \$2,500 through the Labcorp Dependent Care Flexible Spending Account
<b>Your spouse is a full-time student for at least five months of the year or is totally disabled ...</b>	Up to \$2,600 if you have one dependent Up to \$5,000 if you have two or more dependents

## Eligible Dependents

You can be reimbursed for dependent care expenses you have in a Plan year, if the expenses are necessary to allow you and your spouse — if you're married — to work.

These services may be provided inside or outside your home by baby-sitters, companions or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

Your dependent care expenses must be for a:

- dependent child who is under age 13 for whom you are eligible to claim an exemption on your tax return,
- disabled spouse, or
- disabled dependent including a child, parent, grandchild, sibling, niece/nephew, aunt/uncle, in-law or stepchild who is physically or mentally incapable of caring for himself or herself.

Remember, the definition of dependent under the Dependent Care FSA is different from other Labcorp benefit programs.

For a complete list of eligible dependent care expenses, ask for Publication 503 from your local IRS office or on the IRS website at [www.irs.gov](http://www.irs.gov).

## Eligible Dependent Care Expenses

You can be reimbursed through the Dependent Care FSA for the cost of:

- care provided inside or outside your home by someone over age 19 who is not your dependent,
- day care centers qualified under state or local law, that provide care for at least six individuals not normally living at the center,
- FICA and other taxes you may pay for eligible providers,
- preschool or summer program tuition,
- before and after school care expenses, up to age 13.

## Ineligible Dependent Care Expenses

Expenses that cannot be reimbursed through the Dependent Care FSA include:

- care or services provided by your spouse, children under age 19 or anyone you could claim as a legal dependent for federal income tax purposes,
- child support payments,
- healthcare expenses for you and your dependents,
- expenses for overnight camps,
- expenses reimbursed by another spending account plan,
- expenses you claim as a credit on a federal tax return,
- expenses you had before you were, or after you ceased to be, a spending account participant,
- food, clothing or entertainment for a dependent,
- general baby-sitting other than during work hours,
- nursing home expenses, unless the dependent spends at least eight hours a day in your household,
- private school tuition,
- kindergarten tuition, and
- transportation to or from the dependent care location.

If you are uncertain as to whether a dependent care expense qualifies for reimbursement under the Dependent Care FSA, call the PeopleCare Advocacy Center at **1-888-800-4002** for assistance.

## Additional Information About Your Flexible Spending Accounts

### Tax Considerations

You may prefer to use your dependent care expenses to claim a childcare credit when you file your federal tax return. The childcare credit means that you use a special formula to determine the amount of any credit for which you qualify. The credit is then subtracted from any tax you owe.

The Dependent Care Flexible Spending Account is an alternative way to save taxes for those employees who may prefer not to file for the childcare credit. Certain individuals may be better off using the childcare credit instead of the FSA. A tax advisor can help you figure out which option is better for you.

You cannot claim the same expenses for a tax credit and for reimbursement. But childcare expenses that are not reimbursed may still be eligible for the childcare credit on your income tax form. However, any amount you receive through the spending account reduces on a dollar-for-dollar basis the expense amount that you can consider when calculating the tax credit. Any expenses reimbursed from your spending accounts cannot be deducted when you file your income tax return.

#### ACCOUNT RESTRICTIONS

The IRS restricts FSAs in several ways:

- Amounts contributed to one spending account cannot be used to pay expenses from the other.
- If there is any amount left in either of your accounts after the deadline for filing reimbursement requests, the excess contribution cannot be returned to you. (This is called the “use it or lose it” rule.) Forfeited amounts will be used to pay the costs of administering the FSAs.
- Only eligible expenses incurred while you are covered by the Plan and in the calendar year for which you have made contributions (or, with respect to the Health Care FSA, the 2 1/2 month grace period after the end of the calendar year), may be submitted for reimbursement.
- All eligible **Health Care FSA** expenses for 2023 that require a paper claim form, including all supporting documentation, must be postmarked to Optum Financial no later than **June 15, 2024** to receive reimbursement.
- All eligible **Dependent Care FSA** expenses for the 2023 calendar year, including all supporting documentation must be postmarked to Optum Financial no later than **March 31, 2024** to receive reimbursement.

## How to File a Claim for Benefits

To receive reimbursement from your FSAs, obtain a Request for Reimbursement form from Benefits Central or on the [Optum Financial](#) website. Reimbursement for FSA claims is not immediate. You will receive your reimbursement check within two to three weeks from the date your Request for Reimbursement form is received, provided you have included all necessary information and documentation. Claims may be submitted online through Optum Financial for reimbursement and may elect for the reimbursement to be automated through your bank account.

### How to File a Health Care FSA Claim (If Needed)

1. Carefully complete the Request for Reimbursement form.
2. Attach a *fully itemized* bill for services (including specific dates of service) and/or an Explanation of Benefits (EOB) statement. (In order to receive an EOB, you must first file a claim with your or your spouse's health care plan.)
3. Make copies of the documentation for your personal files.
4. Send the completed Request for Reimbursement form along with the required documentation to Optum Financial at the address or fax number listed on the form.

## How to File a Dependent Care FSA Claim

1. Carefully complete the Request for Reimbursement form.
2. Attach a receipt for dependent care services that includes the following information:
  - dependent's name and age
  - costs and dates of service provided
  - provider's name and address, and
  - provider's tax ID number or Social Security number.
3. Make copies of the documentation for your personal files.
4. Send the completed Request for Reimbursement form along with the required documentation to the Claims Administrator at the address or fax number listed on the form.

# Comprehensive Disability Coverage

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One of the greatest threats to financial security is disability — being unable to work and earn continuing income. While no one likes to think about being disabled, it does happen.

At Labcorp, you have broad protection against this kind of loss from three separate but closely related coverages:

- Paid Time Off (PTO), administered by Labcorp,
- Flexible Time Off (FTO), administered by Labcorp,
- Short Term Disability (STD), administered by Reed Group, and
- Long Term Disability (LTD), insured by New York Life Group Benefit Solutions (formerly Cigna)

To learn more about Labcorp disability coverage, refer to the information in this section of your Personal Choice Benefits Handbook. You will find additional information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information in the 2023 Overview Section of the Handbook.

## Your Disability Coverage

Comprehensive Disability coverage includes three separate parts — Paid Time Off (PTO) or Flexible Time Off (FTO), the Short Term Disability (STD) Plan and the Long Term Disability (LTD) Plan. Here's how they work together to provide you with income protection if you are unable to work as a result of disability due to illness, injury or pregnancy.

- Non-exempt employees begin accumulating PTO hours from your date of hire — the amount of PTO hours available to you will depend on your employment status and length of service. You can use earned PTO to provide you with income while you satisfy the waiting period before STD benefits begin. You may borrow PTO, according to the guidelines of the PTO policy, if you have not accrued enough PTO to cover the waiting period. Exempt employees will use FTO to satisfy the STD waiting period.
- Disability coverage goes into effect on the first day of the month following 30 days of employment.
- If you are non-exempt and have sick time hours that were "grandfathered" under a previous benefit plan, all of these hours must be paid out first before any PTO or STD benefits are paid relating to your disability. In the event your employment terminates, you are not entitled to have any grandfathered sick time paid out. Please contact Human Resources for additional information regarding the use of grandfathered sick time hours.

***Any leave to which you are entitled under the Family Medical Leave Act (FMLA) or any applicable state leave laws may run concurrently with your Labcorp disability benefits.***

## Common Features in the STD and LTD Plans

Please refer to the Paid Time Off (PTO) policy for an explanation of your PTO benefits. Please refer to the Flexible Time Off (FTO) policy for details about the FTO provisions. Certain Disability Plan features are common to both the STD and LTD Plans. These are:

### Exclusions for Pre-Existing Conditions

During the first 12 months of coverage, the Labcorp LTD plan does not pay benefits if your disability results from a pre-existing condition.

Your disability is a result of a pre-existing condition if it is the result of an illness, injury or pregnancy for which you have seen a medical practitioner or taken medication during the 3 months before your LTD coverage becomes effective.

If you return from military leave, you may resume the disability coverage in effect prior to your leave. You will not be required to satisfy a new pre-existing condition waiting period if the entire 12-month waiting period had previously been satisfied.

## **Other Exclusions For STD and LTD Plans**

No STD or LTD benefits are payable for any disability caused by:

- war or any act of war, whether declared or not,
- suicide, attempted suicide or self-inflicted injury, while sane or insane,
- taking part in or committing any crime, riot or terrorist act,
- Injury or sickness which resulted from the performance of duties within the functions of military service, or
- revocation, restriction or non-renewal of your license, permit or certification necessary for you to perform the duties of your occupation, solely due to injury or illness (unless otherwise covered by these Plans.)

In addition, no benefits are payable if you:

- are confined to any facility because you were convicted of a crime or public offense, or
- willfully make false statements or representations for the purpose of obtaining benefits, or
- receive Unemployment Compensation during the period you are claiming benefits under the STD Plan.

## **Short Term Disability (STD) Benefit Summary**

The following is a summary of the Labcorp Short Term Disability Plan.

### **When Coverage Begins**

You are automatically enrolled in the Disability Plan. If you are not actively at work due to an illness, injury or pregnancy on the date your STD coverage would have been effective, your STD coverage begins on the first day you return to work at Labcorp.

### **When Coverage Ends**

Your coverage under the STD Plan ends on the earliest of the following:

- midnight on the last day of the month during which your employment with Labcorp terminates;
- the date you change your employment to an ineligible class of employment;
- the date you work for a Labcorp entity that has not adopted the Disability Plan;
- the date you have been on a leave of absence for a reason other than disability for more than 6 months;
- the date you die; and
- the date Labcorp terminates the Plan.

## Benefit Waiting Period

STD benefits begin after you meet the Plan's benefit waiting period. Benefits will begin on the earlier of the following:

- the day after your 5th consecutive work day of absence due to disability, or
- the day after the day your total number of hours of disability are equal to the number of hours you are regularly scheduled to work in a calendar week. The hours of disability required for you to satisfy your benefit waiting period must be incurred within 30 days from the onset of your disability.

If you have PTO hours available, you must use your PTO hours in order to have income during the benefit waiting period. Exempt employees will use FTO for the waiting period.

### What "Disabled" Means under the STD Plan

Under the STD Plan, you are disabled if:

- You are unable to perform one or more of the material duties of your regular occupation solely because of disease, injury or pregnancy, and
- You are unable to perform one or more of the material duties of any position Labcorp makes available for which you are qualified, and
- You are under the regular care and supervision of a Health Care Provider approved by the claims administrator.

"Health Care Provider" means any physician or doctor of medicine, surgeon, optometrist, dentist, podiatrist, osteopathic or chiropractic practitioner, psychologist, Licensed Clinical Social Worker, Certified Addiction Counselor, Licensed Professional Counselor, Licensed Marriage and Family Counselor, Nurse Practitioner and Physician's Assistant who is approved by the claims administrator, duly licensed and acting within the scope of his or her practice but cannot be you or your spouse, daughter, son, mother, father, sister or brother by blood or marriage or domestic partner. "Psychologist" means a psychologist licensed in the state of practice, with a doctorate degree in psychology. All Health Care Providers must be authorized to practice by the state and performing within the scope of their practice as defined by State law.

Benefits are payable in the event of cosmetic surgery if the surgery is considered Medically Necessary; "Medically Necessary" means the surgical procedure is:

- (a) prescribed by a Physician as required treatment of the Injury or Sickness; and
- (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. The length of time certified under the Plan will be determined through review of supporting medical received from the physician.

(The Plan will pay benefits if the Disability is caused by the Employee donating an organ in a non-experimental organ transplant procedure.)

### Payment of Benefits

You will receive STD benefit payments through regular Labcorp payroll according to your normal payroll cycle. All normal payroll deductions will continue with the exception of your contributions to the Employee Stock Purchase Plan. When a period of Disability is less than a full week, the daily amount of benefit paid will be one-fifth (1/5th) of the weekly benefit amount.

Your STD benefits will be reduced by other sources of income, including, but not limited to any earnings paid to you by Labcorp, workers' compensation, mandated state disability plans and any other benefits available to you under federal, state or local law.

### Amount of Benefits

The amount of your STD benefit depends on:

- your length of employment with Labcorp, and
- whether you are enrolled in Disability coverage.

When the claims administrator determines that you meet all of the requirements of the Plan, you will receive the following Short Term Disability benefits if approved.

**STD Benefits:** If you are enrolled in the Labcorp Disability Plan prior to making a claim under the STD Benefit, STD provides an enhanced disability income benefit as shown in the chart below:

NON-EXEMPT STD BENEFITS (IF ENROLLED IN THE DISABILITY PLAN)	
Years of Service	STD Coverage Amount
Less than 3 years	50% of earnings
At least 3 years but less than 8 years	60% of earnings
At least 8 years but less than 15 years	70% of earnings
15 years or more	80% of earnings
EXEMPT STD BENEFITS (IF ENROLLED IN THE DISABILITY PLAN)	
STD Coverage Amount	
100%	

Note:

- Earnings means your straight-time base pay including shift differentials and does not include overtime pay, bonuses or any other forms of extra compensation.
- For non-exempt employees, your STD benefits will be based on your years of service as of the day before the onset of your disability.
- "Service" for purposes of calculating STD benefits will be based on the most recent, continuous period of regular employment.

### Maternity Benefits

The Disability Plan offers special coverage for mothers after the birth of their child. For natural births, mothers will receive 100% of their base pay for five weeks after satisfying the required one week waiting period where PTO can be used, providing a combined six weeks of STD leave. For a cesarean delivery, mothers will receive 100% of their base pay for seven weeks after satisfying the required one week waiting period where PTO can be used, providing a combined eight weeks of STD leave. Non-exempt employees may use up to 40 PTO hours, if available, to receive pay during the required one week waiting period. Exempt employees will use FTO for the waiting period.

Employees must be enrolled in Disability and be determined to be eligible at the onset of their claim in order to receive maternity benefits.

### **When STD Benefits End**

The claims administrator will determine if/when Plan benefits are payable. In no event will benefits continue beyond the occurrence of any of the following:

- The date of your death;
- The date following 182 days of Disability;
- The date the claims administrator determines you are no longer disabled within the meaning of the Plan;
- The date you refuse to cooperate in an independent medical examination;
- The date your disability cannot be confirmed because you have failed to provide the appropriate medical evidence to the claims administrator;
- The date you refused employment offered by Labcorp at a job that can accommodate the limitations of your disability;
- Your employment with Labcorp terminates.

### **STD Benefits and Your Employment Status**

**Prior to STD coverage:** You become eligible for coverage under the STD Plan on the first day of the month following 30 days of employment. If you are disabled before your coverage becomes effective and you are still disabled on the day coverage would otherwise begin, you will not be eligible for STD benefits. If you are still disabled 182 days after the onset of your disability, you will not be eligible for LTD benefits because you were not actively at work on the day your LTD coverage would otherwise begin.

**Disabled after 182 days:** If you become disabled after your STD and LTD coverage become effective and you remain disabled after the 182-day short term disability period, your employment with Labcorp may under certain circumstances terminate. You will be notified if your employment will terminate. However, you will be eligible to apply for LTD benefits, provided you had enrolled for Labcorp LTD coverage.

### **Continuous Disability**

Two consecutive periods of disability are considered one period of disability if they are due to the same cause or condition and are separated by no more than 30 calendar days of work at your normal work schedule. A new waiting period will not be required, and the two periods of disability will be counted toward the benefit maximum.

If you are out on an approved period of disability and have an unrelated condition without a return to work this will be considered once period of disability.

Two consecutive periods of disability separated by more than 30 calendar days of your return to work at your normal schedule will be considered two separate periods of disability even if due to the same cause or condition. A new elimination period and new benefit maximum will be applied when you return to work from the first period of disability.

If a second period of disability is found to be unrelated to the cause or condition of a previous disability and the second disability starts after you return to your normal work schedule for at least one day, it will be considered as a separate period of disability. A new elimination period and new benefit maximum will be applied.

## Working on a Restricted-Duty Basis

If you return to work from a period of disability on a restricted-duty basis or are already working a reduced schedule (due to an illness, injury or pregnancy), you will receive STD benefits — provided you continue to be disabled under the STD Plan. In this instance, your STD benefit payments will be reduced by any pay you receive from Labcorp. For example, if you are normally scheduled to work 40 hours per week and you are entitled to 80% of your base pay during a period of disability, you will receive 80% of your weekly base pay for the week. If you are approved to return to work for 4 hours per day, you will be paid for the 20 hours you work for the week and the remainder in STD benefits up to 80% of your weekly base pay. In both cases you receive 80% of your weekly base pay. **Any partial days of absence due to disability are considered full days for purposes of calculating the 182-day STD period.**

Remember, you must call the STD claims administrator to certify your disability. In the event your employment terminates, you are not entitled to have any sick time paid out.

## Long Term Disability (LTD) Benefit Summary

This summary, together with your certificate of insurance, describe your LTD benefits. Be sure to consult your certificate of insurance for additional information about your LTD benefits.

If you have a disability that extends beyond the 182-day STD period, Labcorp offers additional financial protection through the Long Term Disability (LTD) Plan.

In general, the Basic Disability Plan provides a LTD benefit of 50% of base pay, up to a maximum benefit of \$5,000 a month. The minimum LTD benefit you can receive is the greater of \$100 or 10% of your monthly LTD benefit prior to any reductions for other sources of income.

The Enhanced Disability Plan provides a LTD benefit of 60% of base pay, up to a maximum benefit of \$15,000 a month. The minimum LTD benefit you can receive is the greater of \$100 or 10% of your monthly LTD benefit prior to any reductions for other sources of income.

When calculating LTD benefits, the Plan uses your base pay in effect just before the onset date of your disability.

Your base pay includes shift differentials but excludes bonuses, commissions, overtime pay or other extra compensation.

LTD benefits for certain conditions may be limited to a maximum of 12 months. Your LTD benefits are reduced by other sources of income available to you, including, but not limited to, workers' compensation, any Social Security benefits received by you for yourself or any of your eligible dependents and any other benefits available to you and your dependents under federal, state or local law.

## When Coverage Begins

You are eligible to participate in the LTD Plan on the first day of the month following 30 days of employment. You must enroll in Disability coverage within 30 days of your date of hire or during Annual Benefits Enrollment. If you are not actively at work on the date you are first eligible to enroll in LTD coverage, you will not be eligible to enroll until the first day you return to work at Labcorp. When you enroll in LTD coverage you also agree to have your portion of

the cost of coverage withheld from your pay on an after-tax basis. In addition, if you delay enrollment in Disability benefits, the amount of your STD benefits may be affected.

## **When Coverage Ends**

Your coverage under the Labcorp LTD Plan will end on the earliest of the following:

- the date you are eligible for coverage under a plan intended to replace Labcorp LTD coverage;
- the date Labcorp terminates the Plan;
- the date you change employment to an ineligible of employment;
- the date you work for a Labcorp entity that has not adopted the Labcorp LTD Plan;
- the date you have been on a leave of absence, for a reason other than disability, for more than 6 months;
- the day after the end of the period for which premiums are paid;
- the date benefits end because you did not comply with the terms and conditions of the insurance coverage.

## **Conversion Privilege for Disability Benefits**

If your Labcorp LTD coverage ends because employment with Labcorp ends, or you are laid off or on an uninsured leave of absence for more than 6 months, you may be eligible to convert your Labcorp coverage to an individual policy with the insurer.

To be eligible to convert to an individual policy, you must have been enrolled in the LTD Plan and actively at work for at least 12 consecutive months. If you make application for conversion coverage within 31 days after your Labcorp LTD coverage ends, conversion coverage will be effective as of the date your Labcorp LTD coverage ends. If you make application more than 31 days after your Labcorp LTD coverage ends, you will be required to provide satisfactory evidence of good health at your own expense and your conversion coverage will be effective on the date the insurer agrees to insure you. You must apply for conversion coverage within 62 days of the date your Labcorp LTD coverage ends or you will not be eligible for LTD conversion coverage.

The LTD conversion coverage will provide the same benefits as those in effect under the Labcorp LTD Plan at the time you apply. The premium will be based on the rates in effect for conversion plans at that time.

Conversion coverage is not available if:

1. you are retired or age 70 or older;
2. you are not in active service because of disability;
3. Labcorp coverage is canceled for any reason;
4. you are no longer eligible for Labcorp coverage but are still employed by Labcorp.

## What “Disabled” Means Under the LTD Plan

Under the LTD Plan, you are disabled if:

- During the first 24 months of an illness, injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn more than 80% of your base pay.
- After LTD benefits have been payable for 24 months, you will continue to receive benefits if, solely due to an illness, injury or sickness, you cannot perform all of the material duties of any reasonable occupation for which you may be qualified based on your education, training or experience, and you are unable to earn more than 60% of your base pay in effect on the day before you became disabled.

The claims administrator may ask you to undergo a physical exam performed by a health care provider or other health care professional (see "What Disabled Means Under the STD Plan" above) before benefits are paid under the LTD Plan. In addition, you may be asked to submit to periodic examinations while you are receiving disability benefits. You will not be responsible for paying for these exams. If you refuse a requested medical exam, your LTD benefits will stop.

## Maximum Benefit Period

The LTD Plan pays benefits up to the later of your Social Security Normal Retirement Age\* or the Maximum Benefit Period listed below, based on your age on the day your disability starts.

AGE WHEN DISABILITY BEGINS	MAXIMUM BENEFIT PERIOD
Age 60 or under	The employee's 65th birthday or the date the 60th monthly benefit is payable, if later.
Age 61	The date the 48th monthly benefit is payable.
Age 62	The date the 42nd monthly benefit is payable.
Age 63	The date the 36th monthly benefit is payable.
Age 64	The date the 30th monthly benefit is payable.
Age 65	The date the 24th monthly benefit is payable.
Age 66	The date the 21st monthly benefit is payable.
Age 67	The date the 18th monthly benefit is payable.
Age 68	The date the 15th monthly benefit is payable.
Age 69 or older	The date the 12th monthly benefit is payable.

*\*Social Security Normal Retirement Age is the retirement age in effect under the Social Security Act as of the Policy Effective Date, July 15, 2011.*

*Note: You are not eligible to receive LTD and Labcorp Cash Balance Retirement Plan benefits at the same time.*

## How Your LTD Benefits Are Taxed

Suppose you are out of work and receiving Enhanced LTD benefits (60% of your annual base pay) based on a current salary of \$25,000. Based on these assumptions, you would receive the following monthly LTD benefit:

**\$25,000 salary / 12 months = \$2,084**  
**\$2,084 monthly salary x .6 (benefit percent) = \$1,250**  
**Monthly benefit = \$1,250**

If you choose the option for Enhanced Disability, you will pay 100% of the premium on a pre-tax basis, so 100% of your monthly LTD benefit (\$1,250 in the example above) would be subject to income tax.

If you are in the Basic Disability Plan, Labcorp pays 100% of the cost, so the LTD benefit would also be subject to income tax.

Because individual tax situations vary, you should talk with a tax advisor to understand the specifics of your own situation.

## **What Happens to Other Labcorp Benefits While You Are Receiving LTD Benefits?**

Before your STD benefits end, you will receive a letter outlining the steps you will need to take to:

- convert your Labcorp group life insurance, and
- learn more about the availability of COBRA health care continuation coverage for your Labcorp medical, dental, vision benefits and the Health Care Flexible Spending Account, if you are enrolled at the time you terminate due to LTD.

At the end of your STD benefit period, here is how your participation in other Labcorp Benefits are affected:

<b>LABCORP PLAN</b>	<b>OTHER BENEFIT PLAN STATUS WHILE ON LTD</b>
<b>Medical, Dental, Vision, No Charge Laboratory Testing and Health Care Flexible Spending Account Plans</b>	If you are enrolled in Medical, Dental, Vision, No Charge Laboratory Testing or the Health Care Flexible Spending Account, you may be eligible for COBRA continuation coverage
<b>Basic Life and Optional Life Insurance</b>	If you enrolled in Basic Life and Optional Life Insurance, a conversion option is available
<b>Labcorp Cash Balance Retirement Plan</b>	You may not receive the Cash Balance benefit until either your LTD benefit ends or you reach the normal retirement age (normally age 65)
<b>Labcorp Employees' Retirement Savings Plan</b>	You may contact Fidelity at any time after your termination date with Labcorp to request a rollover or distribution
<b>All Other Benefit Plans</b>	Your participation in all other Labcorp Benefits ends

## **Survivor Income Benefit**

If you die while receiving LTD benefits, a lump sum benefit equal to 6 times your monthly LTD benefit is payable to eligible survivors, including a spouse/domestic partner and/or children under age 21 who are dependents for tax purposes.

## Plan Limitations

There are some situations that could limit your eligibility for benefits under the LTD Plan.

Benefits for disabilities arising from alcoholism, drug addiction or chemical dependency, and certain mental illnesses, are limited up to a maximum of 24 months. This is a combined maximum for all periods of disability under the LTD Plan associated with all these conditions.

This limitation applies if the disability is primarily caused by:

- Alcoholism
- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Drug addiction or abuse
- Eating disorders
- Mental Illness
- Somatoform disorders (psychosomatic illness)

If, before reaching your 12-month lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the conditions listed above. Generally, appropriate care means the determination of an accurate and medically supported diagnosis of your disability by a physician, or a plan established by a physician of ongoing medical treatment and care of the disability that conforms to generally accepted medical standards, including frequency of treatment and care.

## Continuous Disability

Separate periods of disability will be considered continuous if:

1. the period results from the same or related causes as a prior disability for which benefits were payable,
2. the period occurs after receiving disability benefits and you return to work in your regular occupation for less than 6 consecutive months, and
3. you earn less than the percentage of earnings that would still qualify you to meet the conditions of disability during at least one month (see "What Disabled Means Under the LTD Plan").

Any later period of disability, regardless of the cause, that begins when you are eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of disability.

For any separate period of disability which is not considered continuous, another 182-day waiting period will apply.

The certificate of LTD insurance will provide a complete list of exclusions. You can obtain a certificate by contacting the insurer (see "Plan Administration").

## How to File a Claim

### To File for Short Term Disability Benefits

**First**, notify both your supervisor and your local Human Resources representative.

**Second**, call Alight, the Plan's claims administrator, at **1-844-391-6668**. The Alight Customer Service Center is open 9:00 a.m. - 9:00 p.m. (ET) Monday - Friday. Remember, regardless of your waiting period, your notice of claim must be given to Alight no later than five (5) days after your first day of a Disability. When you call to report a claim, you will need to provide Alight with the following information:

- Your personal information (including name, address, phone number, Social Security number and supervisor's name and phone number);
- Your health care provider's name, mailing address, phone number and fax number; and your anticipated length of time away from work due to your disability.

**Third**, if you work in Hawaii, New Jersey, New York, Rhode Island, Puerto Rico or California, you will also need to file for state disability benefits.

The payment of your disability claim is not automatic — you must complete these steps or disability benefits may be delayed or denied. You will qualify for benefits only if there is objective medical evidence that shows you are unable to work. Under most circumstances, if you are not able to contact Alight, a family member or other designee may make the call. Alight will begin evaluating your condition after receiving notification of your disability.

If your disability is job-related, you must:

- contact Alight as described above and
- go to HR Central to find out how to file a claim under Workers' Compensation

## **Medical Certification**

Prior to approving STD benefits, the claims administrator will require proof that you are disabled. Your health care provider must provide objective medical data to establish that you are disabled within the meaning of the STD Plan. The claims administrator may require supplemental forms from your health care provider as often as it determines is necessary while you are claiming STD benefits. Medical evidence that supports your ongoing disability will be required until your disability ceases or your benefits end.

## **Independent Medical Examination**

The claims administrator may require that you be examined by a health care provider selected by the claims administrator when your claim is submitted. No more than a reasonable number of medical examinations will be required. Labcorp pays the cost of examinations performed by health care providers chosen by the claims administrator.

## **Return to Work**

The claims administrator will notify you, your Human Resources Department and Corporate Payroll of your certified disability and your estimated return-to-work date.

If you are unable to return to work, you must contact the claims administrator, your supervisor and your Human Resources Department within three consecutive working days of your estimated return-to-work date. Failure to notify the Human Resources Department within three working days of your return-to-work date may result in the termination of your employment.

Once you are able to return to your regular, full-time or part-time position, you must present Human Resources with a written release from your health care provider. In addition, you must immediately notify your claims administrator of your return to work.

## **Processing Your Claim for Benefits**

After the claims administrator has reviewed your claim, you will receive a written decision telling you whether your claim qualifies for benefits under the STD Plan. This will be within a reasonable period of time, but no longer than 45 days after your claim is received. However, this period of time may be extended as explained in the following paragraphs.

If matters beyond the control of the claims administrator require an extension of time that is more than 45 days after your claim was received, a written notice will be sent to you. It will indicate the reasons for an extension of up to 30 days and will be given to you within the original 45-day period. The notice will specify the circumstances that require the extension of time and the date when the claims administrator expects to make a decision.

A second 30-day extension is permitted if, due to matters beyond the claims administrator's control, a decision cannot be made within the original extension period. You will be notified in writing within the first 30-day extension period if a second extension is required.

If there are unresolved issues that prevent a decision on the claim, and additional information is needed from you or your health care provider, the time period for making the decision will be suspended from the date you were notified of the need for additional information until the date you respond to the notice. The notice sent to you will specify the standards used to determine if you are entitled to the benefit, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

You will be given at least 45 days from the date you receive the notice to provide the requested information.

If it is determined that you are not entitled to STD benefits, the written decision will specify the reasons why your claim was denied and the STD Plan provisions that were the basis for denying your claim, and will describe any additional material or information that is necessary in order to perfect the claim, and explain why this information or material is necessary. If the claims administrator or representative relied on an internal rule, guideline, protocol or other similar criterion when denying your claim, you will be informed and will be offered, at your request and at no cost, a copy of the rule, guideline, protocol or other similar criterion. This decision will also explain the claims review procedures of the STD Plan, and include a notice of your right to bring a civil action under section 502(a) of ERISA following the claims administrator's review of your denied claim.

In the review process, the claims administrator will have discretionary authority to interpret the STD Plan, including any ambiguous provisions, and to determine your eligibility for benefits.

## Claims Review Procedures

If your claim is denied, in whole or in part, then within 180 days after you receive notice of the denial, you may make a written request for a review of your claim to the claims administrator. If you fail to appeal a denied claim within the required time period, you are considered to have permanently waived and abandoned your claim and you may not re-file it.

You will have the right to review, on written request and free of charge, all documents pertinent to your claim. You will have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits. The review will consider all comments, documents, records, and other information you submit, without regard to whether the information was submitted or considered in the initial benefit determination. In the review process, the claims administrator will have discretionary authority to interpret the STD Plan, including any ambiguous provisions, and to determine your eligibility for benefits.

The review will be independent and not rely on the decision made on your initial claim. It will be conducted by someone who was neither the individual who made the initial denial, nor someone who works directly for that individual. If the claim was denied based on a medical judgment, the review will be conducted by the plan administrator or its representative and a qualified health care professional who has appropriate training and experience in the field of medicine relevant to your claim. This health care professional cannot be the individual who was consulted when your initial claim was denied, nor be someone who works directly for that individual. The claims administrator must tell you about any medical or vocational experts whose advice was obtained during your initial claim review, regardless of whether the advice was relied upon in making the benefit determination.

The claims administrator or its representative will provide you with a written decision. If the initial denial is affirmed, the notice will include the specific reasons for the continued denial of your claim. You will be given the specific plan provision that was the basis for the decision, and a statement that you are entitled to receive, upon written request and free of charge, documents, records, and other information relevant to your claim for benefits. If the claims administrator relied on an internal rule, guideline, protocol, or other similar criterion in making the determination, the claims administrator or representative will inform you of this and will offer, at your request and free of charge, a copy of the rule, guideline, protocol, or similar criterion. The notice will also include the following statement:

You and your Plan may have other voluntary, alternate dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

The decision on the review of your claim will be provided within a reasonable period of time, but no more than 45 days after receipt of the request for review. If special circumstances require an extension of the time for review, written notice indicating the reason for the extension will be given to you within such 45-day period. In case of an extension, the decision will be provided within a reasonable period of time but no more than 90 days after receipt of the request for review.

Unless you have exhausted your rights under this claims procedure you may not file a lawsuit against the STD Plan for benefits. You must bring a lawsuit for benefits no later than one year after the final decision on your claim under these claims procedures. If you fail to file a lawsuit within the required time period, you are considered to have permanently waived and abandoned your claim and you may not reassert it in a court or other venue.

# Life & Optional AD&D Insurance

Labcorp understands how important financial security is to you and your family, so Labcorp maintains life and accident insurance plans that include:

- Basic Life Insurance
- Optional Life Insurance
- Dependent Life Insurance
- Optional Accidental Death and Dismemberment (AD&D) Insurance, and
- Business Travel Accident (BTA) Insurance.

To learn more about Labcorp life and AD&D coverage, refer to the information in this section of the Personal Choice Benefits Handbook. You will find additional information about eligibility, enrolling for coverage, paying for coverage, when your coverage starts and stops and other important information in the Overview Section of this Handbook.

## Quick Reference Guide

Use the “Quick Reference Guide” to learn how these plans work together to provide financial security for your family. Then read on for additional information about each of these plans.

TYPE OF PLAN	BENEFIT AMOUNT
<b>Basic Life Insurance</b> (Labcorp-Paid)	2 times annual base pay Maximum: \$1,500,000
<b>Optional Life Insurance</b> (Employee-Paid)	1 times annual base pay 2 times annual base pay 3 times annual base pay 4 times annual base pay 5 times annual base pay 6 times annual base pay Maximum: \$2,000,000
<b>Dependent Life Insurance</b> (Employee-Paid)	Spouse/Domestic Partner—your choice of: \$10,000 \$25,000 \$50,000 \$100,000 \$200,000 Children—your choice of: \$5,000 \$10,000 \$25,000
<b>Optional Accidental Death and Dismemberment (AD&amp;D) Insurance</b> (Employee-Paid)	2 times annual base pay <b>Maximum:</b> \$500,000 <b>Spouse/domestic partner only:</b> 60% of your coverage up to \$300,000 <b>Spouse/domestic partner and children:</b> 50% of your coverage up to \$250,000 for your spouse/domestic partner plus 10% of your coverage up to \$75,000 for each eligible child <b>Children only:</b> lesser of \$75,000 or 15% of your coverage for each eligible child

<b>Business Travel Accident (BTA) Insurance</b> (Labcorp-Paid)	If your annual base income is:	BTA Insurance equals:
	Less than \$15,000	\$50,000
	\$15,000 but less than \$50,000	\$160,000
	\$50,000 but less than \$100,000	\$375,000
	\$100,000 but less than \$200,000	\$750,000
	\$200,000 or more	\$1,000,000

## A Closer Look At Basic, Optional and Dependent Life and AD&D Insurance

If you are absent from work on the date your Life Insurance and AD&D insurance are scheduled to begin, coverage will begin on the date you return to work on a regularly scheduled basis.

If an eligible dependent is confined at home, in a hospital or elsewhere, or is not performing normal daily activities on the date coverage is due to begin, Dependent Life and Optional AD&D Insurance for this dependent begins on the date the confinement ends or normal activities resume.

### Basic Life Insurance

Basic Life Insurance is the foundation of your financial protection plans. It provides a benefit to your beneficiary if you die at any time, from any cause.

Labcorp provides you with Basic Life Insurance equal to two times your annual base pay.

The maximum Basic Life Insurance benefit, regardless of pay, is \$1,500,000.

Although Labcorp pays the cost of your Basic Life Insurance, you are required to include the value of any coverage over \$50,000 in your taxable income. This is called "imputed income." This value is calculated by Labcorp based on Internal Revenue Service (IRS) guidelines and reported on your W-2 form. Imputed income also is subject to Social Security taxes.

### Optional Life Insurance

If you want additional protection, you may elect Optional Life Insurance. As with Basic Life Insurance, Optional Life Insurance provides a benefit to your beneficiary if you die at any time, from any cause, except suicide. You may elect:

- 1 times annual base pay,
- 2 times annual base pay,
- 3 times annual base pay,
- 4 times annual base pay,
- 5 times annual base pay, or
- 6 times annual base pay.

The maximum Optional Life Insurance benefit, regardless of pay, is \$2,000,000.

If you commit suicide, no death benefit will be payable under Optional Life Insurance unless you have been covered under the policy for at least 2 years.

Please note that any time you increase your coverage level, you will have to satisfy a new two-year suicide exclusion waiting period for the *additional* level of coverage.

### Changes in Coverage

During Annual Benefits Enrollment — or if you experience a Qualified Status Change during the year — you can review your life insurance needs and choose optional coverage. (See the "An Overview of Personal Choice" section for more information about Annual Benefits Enrollment.) There are rules on changing the amount of your coverage, though.

If you are currently enrolled in Optional Life or Spouse/Domestic Partner Life Insurance, you may elect more coverage, however, you will need to provide a statement of health to the insurance carrier for approval.

You will receive a statement of health form(s) as needed or you can obtain the form from PeopleCare by calling **1-888-800-4002**, Monday - Friday 8 am - 8 pm ET.

You do not need a statement of health for:

- Basic Life Insurance,
- Child Life Insurance, or
- Optional AD&D Insurance coverage.

## More About Your Life Insurance Coverages

### If Your Annual Base Pay Changes

Your Optional Life Insurance coverage and premium will adjust automatically to keep pace with any changes in your annual base pay. Annual base pay means your annual rate of pay, excluding overtime, shift differential, commissions, bonuses, incentive pay or other forms of extra compensation. In calculating your life insurance coverage, your annual base pay is first rounded up to the next higher \$1,000 if your annual base pay is not already an even \$1,000 amount and is then multiplied by the applicable factor. If you are disabled and away from work on the date your annual base pay changes, your new insurance amount (and premiums, if applicable) will become effective after you return to work for at least one day on a regularly scheduled basis.

### If You Become Disabled

Your Basic Life Insurance coverage continues while you are on short term disability. If you elected Optional Life Insurance, your premiums continue to be deducted from your STD benefits.

If you become eligible for LTD benefits, please refer to the “Comprehensive Disability Plan” section of this Personal Choice Benefits Handbook for additional information about the impact on your Optional Life Insurance coverage.

## Dependent Life Insurance

You may insure your eligible dependents, as follows:

COVERED DEPENDENTS	COVERAGE CHOICES
<b>Spouse/Domestic Partner Life</b>	Your choice of: <ul style="list-style-type: none"><li>• \$10,000</li><li>• \$25,000</li><li>• \$50,000</li><li>• \$100,000</li><li>• \$200,000</li></ul>
<b>Child Life</b>	Your choice of: <ul style="list-style-type: none"><li>• \$5,000</li><li>• \$10,000</li><li>• \$25,000</li></ul>

The Child Life Insurance benefit is limited to \$500 from birth through 6 months in age.

For Child Life, an eligible child is defined as:

1. Your natural child;
2. Your adopted child (including a child from the date of placement with the adopting parents until the legal adoption);
3. Your stepchild (including the child of a Domestic Partner);
4. and who, in each case, is under age 26.

## A “Living” Benefit

The “living” benefit option, also known as the Accelerated Death Benefit, gives you access to additional reserves to meet financial obligations or pay unexpected medical expenses, if you are terminally ill. If you become terminally ill and are determined to have 12 months or less to live, the Plan’s “living” benefit option allows you to receive immediate payment of a portion of your Basic Life and Optional Life Insurance (if enrolled).

If you qualify for this “living” benefit, you can receive up to 80% of your Basic Life and Optional Life Insurance as described below:

PLAN	MINIMUM	MAXIMUM
Basic Life	\$5,000	\$300,000
Optional Life (employee and/or spouse/domestic partner)	\$5,000	\$300,000

Note: The “living” benefit does not apply to Optional AD&D Insurance or Child Life Insurance. The combined Basic and Optional Life “living” benefit maximum is \$500,000.

There is no additional cost for this option. Your premium payments for Optional Life Insurance coverage will be reduced based upon your remaining benefit level. The face amount of your Basic Life and Optional Life Insurance coverages is reduced by any benefits paid out to you. Remaining benefits will be paid to your beneficiary(ies) following your death.

The “living” benefit may be taxable. As with all tax matters, you should consult a tax advisor.

## Converting Your Coverage

If your Labcorp employment ends, you have the option of converting your Basic Life, Optional Life and Dependent Life Insurance — but not your Optional AD&D Insurance — to individual non-term policies. However, you must apply for conversion within the timeframe outlined below. (If you or any covered dependent dies during this election period, you or your beneficiary will still receive your Basic Life, Optional Life or Dependent Life Insurance.)

**Availability:** You must apply for the individual contract and pay the first premium by the later of:

- (1) the thirty-first day after you cease to be insured for the Employee Term Life Insurance; and
- (2) the fifteenth day after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the ninety-second day after you cease to be insured for the Employee Term Life Insurance.

## Optional Accidental Death and Dismemberment (AD&D) Insurance

Optional Accidental Death and Dismemberment (AD&D) Insurance can provide an extra measure of protection for you or your family. AD&D benefits are paid in addition to any life insurance benefits available through the Plan. The Plan pays a benefit if you die or are seriously injured as the result of an accident.

Optional AD&D Insurance offers you coverage of 2 times your annual base pay up to a maximum AD&D benefit of \$500,000.

In addition, you may elect AD&D coverage for your family as described below.

## Optional AD&D Benefits

If you suffer one of the following losses as a result of, and within 365 days of, an accident, the following AD&D benefit will be paid:

TYPE OF LOSS	BENEFIT AMOUNT
Life	100% of coverage amount
One hand, one foot, sight of an eye, loss of speech or hearing	50% of coverage amount
Any two or more of the above	100% of coverage amount
Thumb and index finger of same hand or total paralysis of one limb	25% of coverage amount
Coma	as the lesser of 2% per month and \$1,000 up to up to 100 months; after 100 months a lump sum equal to 100% of the Amount of Insurance minus the amount already paid for Coma
Total paralysis of upper and lower limbs of one side of the body	50% of coverage amount
Total paralysis of both lower limbs	75% of coverage amount
Total paralysis of the upper and lower limbs	100% of coverage amount

## Insurance for Yourself and Your Family

You have the option to choose Optional AD&D Insurance for yourself as well as your eligible dependents through the family coverage. The amount of their coverage is determined by your family status at the time a claim is submitted.

ELIGIBLE FAMILY MEMBERS	COVERAGE AMOUNT
Spouse/Domestic Partner Only	60% of your coverage amount, up to \$300,000
Spouse/Domestic Partner and Children	50% of your coverage amount, up to \$250,000, for your spouse/domestic partner, plus 10% of your coverage amount up to \$75,000 for each eligible child
Children Only	The lesser of \$75,000 or 15% of your coverage amount for each eligible child

For AD&D, an eligible child is defined as:

1. Your natural child;
2. Your adopted child (including a child from the date of placement with the adopting parents until the legal adoption);
3. Your stepchild (including the child of a Domestic Partner);
4. and who, in each case, is under age 26.

Keep in mind that if your Labcorp employment terminates, you cannot convert your Optional AD&D Insurance to an individual policy.

## Seat Belt and Airbag Benefit

Your Optional AD&D Insurance pays an additional benefit if you die in an automobile accident while using an originally equipped, factory-installed, unaltered seat belt/lap and shoulder restraint and/or airbag (supplemental restraint system). The seat belt benefit will be 10% of your AD&D coverage, up to \$25,000. The airbag benefit is also 10% of your AD&D coverage, up to \$10,000.

The use of the seat belt and/or airbag must be verified as part of the accident report or certified by the investigating officer. No benefit is payable if you are either the driver or passenger and the driver was legally intoxicated or under the influence of drugs at the time of the accident, or the driver did not hold a current or valid driver's license.

## What Optional AD&D Insurance Does Not Cover

Optional AD&D Insurance benefits are paid for losses caused by accidents only. No benefits are payable for death or injury caused or contributed to by:

- Disease, bodily or mental infirmity, or medical or surgical treatment of these;
- Suicide or intentionally self-inflicted injury, while sane or insane;
- Participation in a riot or insurrection, or commission of an assault or felony;
- War or any act of war, declared or undeclared;
- Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a physician;
- Driving while intoxicated, as defined by the applicable state law where the loss occurred;
- Hazardous Sports;
- Travel or flight in, or descent from any aircraft, except if employment duties require the Covered Person to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: (a) a scheduled route; or (b) a charter flight seating 15 or more people.

## Business Travel Accident (BTA) Insurance

Because you may be asked to travel on business as part of your job, Labcorp provides Business Travel Accident (BTA) Insurance. BTA Insurance pays a benefit if you die or are seriously injured while traveling on Labcorp business.

The BTA Insurance benefit is based on your annual base pay, as shown below:

IF YOUR ANNUAL BASE PAY IS:	BTA INSURANCE EQUALS:
Earning less than \$15,000	\$50,000
Earning \$15,000 to \$49,999 annually	\$160,000
Earning \$50,000 to \$99,999 annually	\$375,000
Earning \$100,000 to \$200,000 annually	\$750,000
Earning more than \$200,000 annually	\$1,000,000

## BTA Insurance Benefits

If you suffer one of the following losses as a result of, and within 365 days of, an accident, the following BTA Insurance benefit will be paid:

TYPE OF LOSS	BENEFIT AMOUNT
Life	100% of benefit
One hand, one foot, sight of an eye, loss of speech or hearing	50% of benefit
Any two or more of the above	100% of benefit

Thumb and index finger of same hand	25% of benefit
Total paralysis of one upper or one lower limb	25% of benefit
Total paralysis of upper and lower limbs of one side of the body	50% of benefit
Total paralysis of both lower limbs	75% of benefit
Total paralysis of the upper and lower limbs	100% of benefit

## What BTA Insurance Does Not Cover

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Conditions of Coverage* and *Description of Indemnity Benefits* sections of the insurance contract. Capitalized terms used, but not otherwise defined, below will have the meanings provided in the insurance contract.

- intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
- commission or attempt to commit a felony or an assault;
- commission of or active participation in a riot, insurrection or Terrorist Act;
- declared or undeclared war or act of war;
- flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
  - a) except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - b) being flown by the Covered Person or in which the Covered Person is a member of the crew;
  - c) being used for:
    - I. crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - II. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
  - d) an ultra-light or glider;
  - e) being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
  - f) being used for the purpose of parachuting or skydiving;
  - g) designed for flight above or beyond the earth's atmosphere;
- sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- travel in any Aircraft owned, leased or controlled by Labcorp, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by Labcorp if the Aircraft may be used as Labcorp wishes for more than 10 straight days, or more than 15 days in any year;
- voluntary ingestion of any narcotic, drug, poison, gas or fumes, except for ptomaine poisoning, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
- a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
- operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

- employed or retained by Labcorp;
- living in your household;
- a parent, sibling, spouse, domestic partner or child of yours or your spouse/domestic partner.

## Naming Your Beneficiary

You designate the same beneficiary for Basic Life Insurance, Optional Life Insurance, Optional AD&D Insurance and BTA Insurance. Designate or update your life insurance beneficiary information on the Benefits Enrollment System. You are the beneficiary for Spouse/Domestic Partner and Child Life Insurance, provided you choose to cover your dependents. You can change your beneficiaries as often as you wish. Keep in mind you may need to change your Beneficiary Designation if you have a change in family status.

## How to File a Claim

You need to file a claim in order for Life and Accident Insurance benefits to be paid.

You or your beneficiary may request claim forms from the PeopleCare Advocacy Center at **1-888-800-4002**. An advocate will help you complete the forms and file them with the insurance company. Proof of death will be required.

In order for a claim for Life or Optional AD&D Insurance benefits to be processed on a timely basis, be sure to forward the following information to PeopleCare:

- Completed claim form, and
- An official certified copy of the death certificate (if applicable).

PeopleCare will forward this information along with your Beneficiary Designation information (if applicable) to the insurance carrier for processing.

# Employee Stock Purchase Plan

This section of your Personal Choice Benefits Handbook for 2023 is a summary of the Labcorp Employee Stock Purchase Plan (ESPP).

Labcorp's Employee Stock Purchase Plan is designed to permit eligible employees to share in the financial growth and success of Labcorp. The ESPP gives you the opportunity to purchase Labcorp common stock at a discount through automatic, after-tax payroll deductions.

## Quick Reference Guide

If you meet the eligibility requirements, you can participate in the Employee Stock Purchase Plan (ESPP). Participation is voluntary. The ESPP gives you the opportunity to become a shareholder by purchasing Labcorp common stock at a reduced rate through automatic, after-tax payroll deductions. Here is an overview of the opportunities the ESPP provides:

QUESTIONS	ANSWERS
<b>Who can join?</b>	<p>You can, if you are a U.S employee (1) who is employed by a subsidiary of Labcorp that participates in the ESPP, (2) who has completed 6 months of service as of the beginning of the offering period, and (3) whose customary employment is for more than 20 hours per week.</p> <p>You are not eligible to participate if you (1) are employed by a subsidiary of Labcorp that does not participate in the ESPP, (2) are a seasonal employee whose employment is not for more than 5 months a year, or (3) own (or would own) 5% or more of Labcorp's common stock.</p>
<b>How do I enroll?</b>	<p>You can enroll two ways: online or by phone. Login to Fidelity NetBenefits at <a href="http://www.netbenefits.fidelity.com">www.netbenefits.fidelity.com</a> or call Fidelity Stock Plan Services at <b>1-800-544-9354</b>.</p>
<b>How much can I deduct?</b>	<p>You can contribute from 1% to 10% of your base pay, including shift differential, to purchase Labcorp common stock at a 15% discount. Contributions are made through payroll deduction on an after-tax basis.</p>
<b>Who maintains my account?</b>	<p>Fidelity Investments maintains individual accounts for all ESPP participants.</p>
<b>Who pays fees related to the purchase of stock?</b>	<p>Labcorp pays all fees in connection with purchases made through payroll deduction.</p>
<b>Who do I call?</b>	<p>Call a Fidelity Stock Plan Services Representative at 1-800-544-9354 Monday through Friday, 8 a.m. to midnight Eastern Time if you have questions or if you want to sell your Labcorp common stock.</p>

## A Closer Look At How the Labcorp ESPP Works

### Who Is Eligible

You are eligible to participate in the Labcorp Employee Stock Purchase Plan (ESPP) if:

- you are a U.S. employee of a subsidiary of Labcorp that participates in the ESPP,
- you have completed six months of service as of the beginning of the offering period, and
- your customary employment is for more than 20 hours per week.

You are not eligible to participate in the (ESPP) if you:

- are employed by a subsidiary of Labcorp that does not participate in the ESPP,
- are a seasonal employee whose employment is not for more than 5 months a year, or
- own (or would own by participating in the ESPP) 5% or more of Labcorp's common stock.

If you cease to be eligible to participate in the plan during an offering period, you will be refunded all funds accumulated in your account.

### Who Pays the Cost

You pay the cost of purchasing Labcorp common stock — at a 15% discount — on an after-tax basis through automatic payroll deductions. The 15% discount is applied to the lower of the average high and low sales price on the first day of an offering period or the average high and low sales price on the last day of the offering period.

Labcorp pays all fees related to the purchase of Labcorp common stock through the ESPP. However, if you purchase shares outside of the Plan, you pay all commissions and charges in connection with purchases made other than by payroll deduction. You pay all commissions and charges as a result of selling your shares of Labcorp common stock.

### How to Enroll

If you want to enroll in the ESPP, you need to open an account by completing the online application using Fidelity NetBenefits at [www.netbenefits.fidelity.com](http://www.netbenefits.fidelity.com) or you can request a Fidelity Account application by calling **1-800-544-9354** Monday through Friday 8 a.m. to midnight Eastern Time. When you complete the application process and elect your payroll deductions, you authorize Labcorp to deduct contributions to the ESPP directly from your paycheck on an after-tax basis.

### When You Can Enroll

You can enroll in the ESPP after you have met the eligibility requirements. Payroll deductions will begin with the first scheduled paycheck of the next offering period. Offering periods begin on the first trading day of January and July each year, which are generally on January 1 and July 1.

You should enroll online or by phone through Fidelity Stock Plan Services no later than 15 calendar days before the start of an Offering Period.

### Your Payroll Deduction

You may designate from 1% to 10% of your base pay — including shift differential — as your ESPP contribution to be used to purchase Labcorp common stock through convenient payroll deductions. Your election must be in 1% increments and may not exceed \$25,000 of the fair market value of Labcorp common stock per calendar year. The amount you designate is deducted from your paycheck on an after-tax basis. No interest is credited to your ESPP account.

### Changing the Amount of Your Payroll Deduction

You can increase or decrease the amount of your payroll deduction online using [www.netbenefits.fidelity.com](http://www.netbenefits.fidelity.com)

or by calling Fidelity Stock Plan Services at **1-800-544-9354** no later than 15 calendar days before the beginning of an offering period. Changes are effective with the first payroll of the next offering period. You will not receive a refund of year-to-date contributions. Any contributions for the current offering period will be applied to the purchase of Labcorp common stock.

## Discontinuing Contributions

You can stop contributing to the ESPP at any time by contacting Fidelity Stock Plan Services and changing your payroll deduction to zero percent. Once you stop your contributions, you cannot begin participating again until the next offering period. Any contributions made during an offering period in which you stop contributions will not be refunded; they will be applied to the purchase of Labcorp common stock.

## How Shares Are Purchased

Shares of Labcorp common stock are purchased semiannually and deposited into your Fidelity account.

## Other Plan Provisions

### Selling Stock

After shares of Labcorp common stock have been purchased, you can sell your Labcorp common stock at any time. To direct a sale, go online or call Fidelity Stock Plan Services at **1-800-544-9354** and indicate your order to sell. While you are a Labcorp employee purchases and sales of Labcorp common stock are subject to Labcorp's Insider Trading Policy found in the Code of Business Practices on The Point.

### Transfer Restrictions

You cannot transfer or pledge your right to receive shares of Labcorp common stock. You may purchase the shares of Labcorp common stock only in your name. If you wish to transfer or pledge your shares of Labcorp common stock, you will need to take actual delivery of your shares of Labcorp common stock.

### Blackout Periods

Under Labcorp's Insider Trading Policy, blackout periods prohibit certain key employees from performing any transactions involving Labcorp common stock, including any Labcorp common stock purchased under the ESPP (whether held in their Fidelity account or not). The blackout period begins three weeks before the end of each calendar quarter and ends two business days following the release of Labcorp's earnings for the quarter. For more information, please refer to Labcorp's Insider Trading Policy found in the Code of Business Practices on The Point.

### Share Certificates

Certificates for shares of Labcorp common stock purchased through the ESPP will be held by the broker in "street name" (without charge) but can be delivered to you upon written request for a fee. The number of shares credited to your ESPP account is shown on your Fidelity account statement. This feature protects against loss, theft, or destruction of stock certificates.

Like any shareholder, you have the right to vote the shares of Labcorp common stock held in your Fidelity account and receive information, such as annual reports and proxy statements.

### Account Statements

You will receive an account statement from Fidelity Investments after each offering period. You should keep statements you receive because the statements will verify your actual cost for the shares of Labcorp common stock. When you sell the Labcorp common stock, you will need to know the cost in order to determine the gain or loss on the sale.

## Taxation

When you sell shares of Labcorp common stock purchased through the ESPP, you are required to report the amount of ordinary income for tax purposes. If you hold your shares for a minimum of one year after the purchase date or two years after the grant date, whichever period is longer, you may be entitled to special tax treatment, known as a “qualified disposition”. However, if you sell your shares prior to one year after the purchase date or two years after the grant date, whichever period is longer, the shares are not entitled to the special tax treatment of a qualified disposition. Instead, you are required to report the value of the discount as ordinary compensation income. In addition, you may owe tax on any capital gains resulting from the sale of your stock. You should talk with a tax specialist before selling any shares of Labcorp common stock purchased through the ESPP.

## Leaves of Absence

### Authorized Leaves of Absence

If you go out on an authorized leave of absence, such as short term disability, and do not terminate employment (as determined for purposes of the ESPP), you can remain a participant in the ESPP and elect either (1) for your payroll deductions to stop following the procedures described above under “Discontinuing Contributions” or (2), for your payroll deductions to continue from eligible earnings paid to you by your employer during your authorized leave of absence. Any funds in your ESPP account will be applied toward the purchase of Labcorp common stock at the end of the offering period in which your leave begins.

### If You Terminate Employment

If you terminate employment with Labcorp or a subsidiary of Labcorp participating in the ESPP other than on account of death, you are no longer eligible to purchase shares of Labcorp common stock through the ESPP.

Any payroll deductions made during the offering period in which your employment ends will be refunded to you within 30 days following receipt of your termination notice.

However, you can maintain your individual account with Fidelity Investments and make direct purchases of Labcorp common stock if you wish. In this case, you pay the full cost of each transaction and no discount will apply.

If you terminate employment on account of death, the legal representative of your estate or your beneficiary(ies) may elect, within 3 months of your death (or by the end of the current offering period, if earlier), either to (1) receive a refund of the payroll deductions you contributed during the offering period or (2) apply the payroll deductions you contributed during the offering period to the purchase of Labcorp common stock at the end of the offering period.

## The TELUS Health Program

The TELUS Health Program provides valuable services and information at no cost to you. TELUS Health offers confidential consultations and short-term counseling for you and your family members. TELUS Health can serve as a resource for the following:

- helping you find child or elder care
- locating schools and educational financing information
- providing investment and retirement planning information
- helping you to resolve work issues
- helping address alcohol or drug abuse issues, and
- other personal issues.

**TELUS Health consultants are available 24 hours, 7 days a week by calling 1-888-267-8126.**

### Who Pays for the Cost of Coverage

Labcorp pays the entire cost of providing the TELUS Health Program, which includes the cost for short-term counseling visits.

You and your dependents may receive up to 10 counseling visits per year for each unrelated problem.

If alternative counseling or other treatment is received, you will be responsible for paying the cost for those services.

### A Closer Look At How the TELUS Health Program Works

You are not expected to have all the answers to life's challenges. That is why Labcorp provides the TELUS Health Program. TELUS Health can provide you with need-to-know information about financial planning, continuing your education, legal assistance and home repair needs. In addition, TELUS Health offers assistance for problems that may disrupt work and family life including elder care needs, mental health issues, addiction and work-related problems.

TELUS Health offers free, confidential consultation on the phone or in person with a caring professional consultant. TELUS Health.com is an award-winning website where you can watch short videos, listen to podcasts, read articles, order or download free materials like booklets and CDs, complete personalized searches and referrals for childcare and elder care resources. TELUS Health also provides referrals to local and national resources.

### TELUS Health Consultants

All TELUS Health consultants hold master's degrees in social work or a human services field and have a minimum of three years of practical experience. When they are hired, consultants are required to complete TELUS Health thorough orientation and training program followed by a competency certification program. Consultants spend an average of 5% to 10% of each workweek in training activities to provide assessments, consultations, and referrals for TELUS Health services.

### Employer Referral

Managers and supervisors may refer employees to TELUS Health if an employee asks for help or has personal problems that are affecting job performance. These referrals may be made in the hope of preventing further job impairment or disciplinary action. Job security or promotions are not affected by the decision to accept referral to TELUS Health. Under certain circumstances, referral to TELUS Health may be mandatory and a condition of continued employment.

### When You Call

When you call TELUS Health at **1-888-267-8126**, a consultant will ask your name, your company, and your location. An appointment will be made to discuss your situation by phone. When necessary, your consultant can make a referral to a local provider for short-term counseling visits. If you need a referral, you and your dependents may receive up to 10 short-term counseling visits per year for each unrelated problem — at no

cost to you. However, if it is determined that long-term counseling may be needed to adequately address the situation, your consultant will not be able to grant the 10 short-term visits.

TELUS Health consultants are available on a 24-hour basis for emergency or urgent situations.

## Hospital Pre-Certification

TELUS Health staff is specially trained to evaluate and recommend treatment for individuals with psychological, drug or alcohol problems.

If you or a family member is in need of possible hospitalization for one of these problems, you must get Prior Authorization for the treatment by calling the Prior Authorization telephone number for the Labcorp Medical Plan in which you are enrolled before entering the hospital in order to receive maximum benefit levels from the Labcorp Medical Plan.

## The Adoption Assistance Plan

The Adoption Assistance Plan provides benefits if you adopt a child. TELUS Health also can provide agency referrals and guidance with the adoption process.

### A Closer Look At How the Adoption Assistance Plan Works

You can request up to a lifetime maximum of \$3,000 in reimbursement for covered expenses for the legal adoption of any eligible child. If both the adopting mother and father are Labcorp employees, the combined maximum benefit is \$3,000 per lifetime.

Covered expenses include:

- placement fees from a public or private adoption agency,
- legal fees,
- court fees, and
- child care charges when the child temporarily lives at another location before placement in your home.

To file a claim for reimbursement, contact TELUS Health at **1-888-267-8126**.

You may also take an unpaid leave of absence to care for your child, with your supervisor's approval. In addition, you can contact TELUS Health if you need help finding a day care center, nursery school or special needs program, or to apply for tuition aid.

### What's Not Covered

Some expenses that are not covered include:

- adoption by a stepparent
- medical expenses for the biological mother
- transportation and travel expenses for anyone associated with the adoption
- any expenses for the biological parents
- voluntary donations or contributions to the adoption agency, and
- costs to obtain guardianship or custody of the child.

If you are unsure about which expenses are covered, or need more information about the Plan, contact TELUS Health at **1-888-267-8126**.

## Accident Insurance offered by Voya Employee Benefits

Accident Insurance can help relieve some of the financial stress that goes along with an accidental injury either at work or at home.

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident that occurs on or after your coverage effective date. The benefit amount depends on the type of injury and care received. You can purchase either Basic or Enhanced Accident Insurance for yourself, your spouse/domestic partner and your children.

## Critical Illness Insurance offered by Voya Employee Benefits

No matter what type of medical coverage you have, if you are diagnosed with a critical illness, out-of-pocket expenses can add up quickly. Critical Illness Insurance can provide you and your family with the additional financial protection you may need for expenses associated with an unexpected, covered critical illness.

Critical Illness Insurance provides a benefit payment upon the diagnosis of a covered illness or condition on or after your coverage effective date. This coverage also includes a Wellness Benefit that pays an annual benefit when the covered person has an annual physical exam or covered health screening test. You can purchase Critical Illness Insurance for yourself, your spouse/domestic partner and/or your children. Critical Illness Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

## Hospital Confinement Indemnity Insurance offered by Voya Employee Benefits

Costs for hospital stays add up quickly – from medical bills; to travel, food and lodging costs; to the day-to-day expenses that don't stop while you are admitted. Voya's Hospital Confinement Indemnity Insurance can help relieve some of these financial pressures if you are admitted to the hospital.

Hospital Confinement Indemnity Insurance pays a daily benefit if you have a covered stay in a hospital, critical care unit or rehabilitation facility on or after your coverage effective date. You can use this money for any purpose you like, including: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses.

Hospital Confinement Indemnity Insurance is a limited benefit policy. This is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

## Identity Theft Protection from ID Watchdog

Every two seconds thieves steal another identity. Most victims only discover that they have a problem when they are denied credit, are contacted by the police or receive bills for things they have never purchased.

That's why ID Watchdog gives you the tools and protection to stop identity theft early and fix it fast including:

- Proactive monitoring of traditional and non-traditional credit
- High-risk transaction and internet black-market monitoring
- Reimbursement insurance for up to \$1 million in identity theft-related expenses
- Fully-managed resolution services that have never failed to restore an identity

## The Legal Assistance Plan

The Labcorp Legal Assistance Plan offers you and your family convenience, value and peace of mind by providing quality legal services. The Plan provides access to more than 14,000 in-network attorneys. You may also use your own attorney and be reimbursed according to a determined fee schedule.

### A Closer Look At How the Legal Assistance Plan Works

Once you enroll in the Plan, you and your eligible dependents will have access to professional legal representation at an affordable price. If you have a situation that requires legal attention, simply call MetLife Legal Plans at **1-800-821-6400** Monday through Friday from 8:00 a.m. to 7:00 p.m. Eastern Time. A Client Service Representative will give you the address and phone number of the in-network attorney(s) in your areas. You can then contact the in-network attorney to schedule an appointment.

### Covered Services

When you select an in-network attorney, you can consult with that attorney any number of times for a variety of personal legal services, including:

- consumer protection matters,

- debt matters,
- document review,
- family law,
- real estate matters,
- traffic/criminal matters, and
- wills, living trusts and estate planning.

For a full list of covered services, contact MetLife Legal Plans at **1-800-821-6400**.

## What's Not Covered

Any business-related matter (including rental property) and issues related to your employer are not covered under the Plan. In addition, appeals, class action suits, any matter involving MetLife Legal Plans or a Plan Attorney and any matter where a spouse or dependent's interests may conflict with yours are not covered. The Plan does not cover third-party costs.

Coverage is not available if you are currently receiving or have received legal services prior to enrollment.

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# Life Events

Changes to your benefits due to any of the Life Events listed below must be made **within 30 days** of the Qualifying Life Event. You can make changes to your benefit elections on the Benefit Enrollment System.

YOU'RE MOVING	
<b>Step 1</b>	Update your personal information.
<b>Step 2</b>	Go to the Benefit Enrollment System to confirm that your current medical option is still available based on your new ZIP code. Changes to your medical coverage will only be allowed if you are moving to a ZIP code in which your current medical option is not available.
YOU'RE HAVING OR ADOPTING A CHILD	
<b>Step 1</b>	Add your child to your Labcorp medical, no charge laboratory testing, dental and/or vision coverage through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday.
<b>Step 2</b>	Enroll in Optional Life, Dependent Life and/or Optional Accidental Death and Dismemberment (AD&D) Insurance or change your current coverage amounts.
<b>Step 3</b>	Enroll in or change contributions to your Flexible Spending Accounts (FSAs).
YOU'RE GETTING MARRIED	
<b>Step 1</b>	Add your spouse to your Labcorp medical, no charge laboratory testing, dental and/or vision coverage through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday.
<b>Step 2</b>	Update your Life Insurance and LabCorp 401(k) Plan beneficiary information.
<b>Step 3</b>	Add your dependents to your Labcorp medical, no charge laboratory testing, dental and/or vision coverage.
<b>Step 4</b>	Enroll in Optional Life, Dependent Life and/or Optional Accidental Death and Dismemberment (AD&D) Insurance or change your current coverage amounts
<b>Step 5</b>	Enroll in or change contributions to your Flexible Spending Accounts (FSAs).
<b>Step 6</b>	Stop medical, dental, vision and/or Life Insurance coverage for yourself and/or your dependents if you are enrolling for benefits through your spouse's employer.
YOU'RE LEGALLY SEPARATED OR GETTING DIVORCED	
<b>Step 1</b>	Remove your spouse from your Labcorp medical, no charge laboratory testing, dental and/or vision coverage through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday. The dependent may be eligible for COBRA continuation coverage.
<b>Step 2</b>	Remove any dependent children, if they are gaining coverage through your former spouse, from your Labcorp medical, dental and/or vision coverage through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday. Your dependent children may be eligible for COBRA continuation coverage.
<b>Step 3</b>	Stop contributing to or decrease contributions to Flexible Spending Accounts (FSAs), if you are currently contributing.
<b>Step 4</b>	Stop participation in Dependent Life and Optional Accidental Death and Dismemberment (AD&D) Insurance. You may wish to continue your dependent children's coverage if they are not gaining coverage under your spouse's employer.
<b>Step 5</b>	Update your Life Insurance and Labcorp 401(k) Plan beneficiary information.

YOU OR A DEPENDENT DIE(S)	
<b>You Die</b>	
<b>Step 1</b>	Your beneficiary should contact PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday.
<b>Step 2</b>	File a claim for Life Insurance and Optional Accidental Death and Dismemberment (AD&D) Insurance.
<b>Step 3</b>	Enroll for COBRA health continuation coverage. Your dependents receive COBRA coverage at no cost for the first 6 months following your death —provided they were enrolled in Labcorp medical, dental and/or vision coverage at the time of your death.
<b>Your Dependent Dies</b>	
<b>Step 1</b>	Remove your dependent from your Labcorp medical, no charge laboratory testing, dental and/or vision coverage through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday.
<b>Step 2</b>	Update your Life Insurance and Labcorp 401(k) Plan beneficiary information.
<b>Step 3</b>	File a claim for Dependent Life Insurance.
<b>Step 4</b>	Remove your dependent from your Dependent Life and/or Optional AD&D Insurance coverage or change coverage amounts.
<b>Step 5</b>	Stop contributing to or decrease contributions to your Flexible Spending Accounts (FSAs), if you are currently contributing.
OTHER SITUATIONS	
<b>Your Dependent No Longer Meets the Age or Dependent Status Requirement</b>	
<b>Step 1</b>	Remove your dependent from your Labcorp medical, no charge laboratory testing, dental and/or vision coverage through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday. The dependent may be eligible for COBRA health continuation coverage.
<b>Step 2</b>	Stop contributing to or decrease contributions to your Flexible Spending Accounts (FSAs), if you are currently contributing.
<b>Your Spouse/Domestic Partner's Eligibility for Coverage Changes</b>	
<b>Step 1</b>	Update your personal information through the Benefit Enrollment System or by calling PeopleCare at <b>1-888-800-4002</b> , 8 a.m. to 8 p.m. ET, Monday - Friday. Add your dependents to your Labcorp coverage if your spouse/domestic partner loses coverage under his or her employer or another plan. If you waived your Labcorp coverage because you were covered under your spouse/domestic partner's employer, you may enroll yourself and your dependents in Personal Choice benefits.
<b>Step 2</b>	Drop your and your dependents' Personal Choice coverage if your spouse/domestic partner (and you and your dependents) becomes eligible for coverage under your spouse/domestic partner's employer.

# Plan Administration

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This information is part of your Personal Choice Benefits Handbook for 2023, which constitutes the summary plan description (SPD) for the Labcorp health and welfare and retirement plans offered through the Labcorp Personal Choice Benefits Program subject to the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs certain employee benefit plans. The Handbook provides only a summary of the plans as in effect on January 1, 2023 for employees of Labcorp on or after January 1, 2023. In the event of any conflict between information contained in this Handbook and the official Plan documents, the official Plan documents govern.

This Handbook does not establish enforceable employee rights, contractual or otherwise, and does not establish an employment relationship enforceable by employees. The provisions of the Handbook do not constitute a contract and are subject to change at any time without notice (except as otherwise required by law). Nothing in this Handbook or any other publication from Labcorp shall interfere with or limit in any way the right of Labcorp to terminate any employee's employment without cause or notice at any time, confer upon any employee any right to continue employment with Labcorp, or change an employee's existing at-will employment status. You remain an employee at-will, which status may be changed only by an authorized Labcorp representative in writing.

Labcorp reserves the right to change, suspend or terminate any benefits and any plan at any time. The information in this 2023 Handbook supersedes and replaces all prior summary plan descriptions, program summaries, communications, whether oral or written, or other information relating to the plans, benefits and programs. Separate summary plan descriptions describe the provisions of the Medical Plan applicable to other groups of employees.

## Plan Administration

This section of Your Personal Choice Benefits Handbook contains information on the administration and funding of your Labcorp benefit plans, as well as your rights as a plan participant. While you may not need this information on a daily basis, it's important to understand your rights and the procedures you need to follow when certain situations arise.

## Administrative Information

### Plan Year

The Plan Year is each January 1 to December 31.

### Plan Administrator/Sponsor

The Plan Sponsor for all plans is:

Laboratory Corporation of America Holdings  
Attn: Corporate Benefits  
531 South Spring Street  
Burlington, NC 27215  
**1-336-222-7566**

Laboratory Corporation of America Holdings is also the plan administrator for the Labcorp benefit plans.

As plan administrator, Labcorp has the sole discretionary authority to interpret and apply the terms of each of the plans and to determine all claims for benefits. In the case of certain insured plans, the plan administrator has delegated its authority to interpret and apply plan terms, and determine benefits claims, to one or more individuals and/or to a claims administrator. The decisions of the plan administrator or claims administrator (as the case may be) are final and binding on all persons and may not be overturned absent an abuse of discretion. The chart in the section "Plan Information" shows the names and addresses of the claims administrators appointed for various plans.

Labcorp's Employer Identification Number (EIN) assigned by the Internal Revenue Service (IRS) is 13-3757370.

## Agent for Service of Legal Process

The agent for service of legal process for all plans is:

General Counsel, Law Department  
Laboratory Corporation of America Holdings  
531 South Spring Street  
Burlington, NC 27215

Legal process can also be served on the plan administrator or respective claims administrators for the welfare plans or on the trustees or plan administrator for the Employees' Retirement Savings Plan or the Cash Balance Retirement Plan. The addresses can be found in the "Plan Information" section.

## Plan Affiliates

Labcorp benefit programs cover all regular full-time and regular part-time employees who are eligible for benefits within Laboratory Corporation of America Holdings (and all of its participating affiliates) and Laboratory Corporation of America.

## Future of Plans

Although Labcorp expects to continue its employee benefit plans, it reserves the right to change or discontinue, at any time, any part or all of the benefit coverage described in this Personal Choice Benefits Handbook. Labcorp also reserves the right to increase or decrease any employee contributions for plan coverage or to require contributions for any coverage that currently is non-contributory.

Labcorp's decision to change or end the plans may be due to changes in federal or state law governing welfare or retirement benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company or any other reason. If Labcorp modifies or terminates a plan, it may decide to set up a new plan providing different, similar or identical benefits, but it is not obligated to do so.

Certain benefits provided by the Labcorp 401(k) Plan and Cash Balance Retirement Plan may only be eliminated on a prospective basis. Also, upon the complete termination of either the Labcorp 401(k) Plan or Cash Balance Retirement Plan, you will become 100% vested in your accrued benefit in the terminated Plan. Upon a partial termination of either Plan, if the partial termination affects you, you will become 100% vested in your accrued benefit in the partially terminated Plan.

Upon the complete termination of the Cash Balance Retirement Plan, the Plan assets will be distributed in accordance with ERISA. Upon the complete termination of the Labcorp 401(k) Plan, the Plan assets will be distributed in the same manner as the assets would otherwise be distributed (upon separation from service, etc.) unless the Plan termination amendment provides otherwise. Upon the complete termination of a welfare plan, generally all claims incurred prior to the termination date will be paid.

Plan participants and beneficiaries have no vested rights in any plan or program other than in their vested accrued benefits in the Labcorp 401(k) Plan and Cash Balance Retirement Plan; in particular, no vested rights arise in those benefits currently made available to retirees after employment ends.

## Legal Limitations

Government rules limit the total benefits payable to highly compensated employees under Labcorp's qualified retirement and savings plans. Government rules may also require that under certain circumstances, highly compensated employees and/or key employees must be prohibited from participating in plans permitting employees to participate on a before-tax basis in medical, dental or vision plans or to contribute to FSAs. You would be notified if your benefits ever were affected by these rules.

## Plan Information

Administrative information for Labcorp's group benefit plans subject to ERISA is shown below.

WELFARE PLANS				
Formal Plan Name	Plan No.	Insured By	Claim Administered By	Contributions and Funding
Laboratory Corporation of America Holdings Group Benefits Plan	510	Combination of Labcorp (self-insured) and insured	See below	See below
Laboratory Corporation of America Holdings Medical Benefit Plan	510	Labcorp (self-insured)	<p>Aetna, Inc. 151 Farmington Ave. Hartford, CT 06156 1-800-223-7331</p> <p>BCBS BlueCross BlueShield P.O. Box 100121 Columbia, South Carolina 29202 1-877-275-9787</p> <p>Cigna 7555 Goodwin Road Chattanooga, TN 37421 1-800-854-7315</p> <p>UnitedHealthcare PO Box 30432 Salt Lake City, UT 84130-0432 1-800-830-1501</p> <p>OptumRx 2300 Main Street Irvine, CA 92614-9731 1-888-691-0169</p> <p>Optum RX Specialty Pharmacy 855-427-4682</p>	<p>Unfunded; Labcorp and participant contributions;</p> <p>Participant portion is paid before-tax</p>
Laboratory Corporation of America Holdings No Charge Laboratory Testing Benefit	510	Labcorp (self-insured)	Labcorp 531 S. Spring St. Burlington, NC 27215	Self-funded; Labcorp pays all costs
Laboratory Corporation of America Holdings Dental Plan	510	Labcorp (self-insured)	Cigna Dental Claims PO Box 188037 800-854-7315	Unfunded; Labcorp and participant contributions;
WELFARE PLANS				
Formal Plan Name	Plan No.	Insured By	Claim Administered By	Contributions and Funding
			Chattanooga, TN, 37422 <b>1-800-854-7315</b>	participant portion is before-tax
Laboratory Corporation of America Holdings Vision Plan	510	Vision Service Plan	Vision Service Plan PO Box 385020 Birmingham, AL 35238 <b>1-800-877-7195</b>	Insured; Participant contributions made on a before- tax basis

<b>Laboratory Corporation of America Holdings Medical Expense Reimbursement Plan</b>	510	Labcorp (self-insured)	OPTUM FINANCIAL 11405 Bluegrass Parkway Louisville, KY 40299 <b>1-888-800-4002</b>	Unfunded; Participant contributions made on a before- tax basis
<b>Laboratory Corporation of America Holdings Short Term Disability Plan</b>	510	Alight	Alight PO Box 6248 Broomfield, CO 80021 <b>1-844-391-6668</b>	Self-funded; Labcorp pays all costs
<b>Laboratory Corporation of America Holdings Long Term Disability Plan</b>	510	New York Life Benefits Solutions	New York Life Benefits Solutions <b>1-800-644-5567</b>	Insured; Labcorp and participants pay premiums; participant portion is pre-tax
<b>Laboratory Corporation of America Holdings Life Insurance Plan</b>	510	MetLife	MetLife 200 Park Avenue New York, NY 10166 <b>1-800-638-6420</b>	Insured; Labcorp and participants pay premiums; participant portion is after-tax
<b>Laboratory Corporation of America Holdings Legal Assistance Plan</b>	510	MetLife Legal Plans	<b>1-800-821-6400</b>	Insured; Participant pays all premiums
<b>TELUS Health (counseling only)</b>	510	TELUS Health	<b>1-888-319-0755</b>	Self-funded; Labcorp pays all costs

## Address Changes

You should notify your local Human Resources Department in writing of any change of address so benefit payments can be sent to you or to your spouse or other beneficiary. This is especially true if payments are to be postponed until a later date.

## Inability to Receive Payment

If you cannot receive benefit payments yourself because of physical or mental disability and if there is no one officially in charge of your affairs, Labcorp will send payments to the person or persons taking care of you after acceptable evidence of such arrangement is presented.

## Assignment of Benefits

You cannot assign the benefits you have earned under the Labcorp benefit plans to pay a debt or to satisfy claims of bankruptcy or creditors. However, your benefits can be paid to a spouse, former spouse, child or other dependent if a court issues a domestic relations order requiring it, and if the Plan deems that order to be qualified.

If you become legally separated or divorced, a portion of all your benefits under the Labcorp retirement plans may be assigned to someone else to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent.

You may also be required to provide group health coverage to one or more of your children pursuant to a qualified medical child support order. Participants and beneficiaries may obtain, without charge, from the plan administrator a copy of the procedure used to determine if a medical child support order is qualified.

## Qualified Domestic Relations Order

Federal law prohibits assignment or attachment of your retirement benefits, except under a Qualified Domestic Relations Order (QDRO). A QDRO is a court order, issued in connection with a divorce or family support

proceeding, which orders the plan to pay benefits to someone other than you and which meets certain standards established under the Internal Revenue Code. Labcorp must comply with these court orders, and any such payment will not violate the rule of non-assignability of benefits.

The plan administrator may be required to begin making payments from your savings and/or retirement plan accounts while you're still working. These payments could even exhaust the total value of these accounts. The plan administrator has no discretion in these matters.

Each domestic relations order attempting to effect assets in an ERISA plan must meet certain qualification requirements. Labcorp reviews all QDROs to determine whether they are qualified under ERISA.

Participants and beneficiaries may obtain, without charge, a copy of the QDRO procedures from the Plan Administrator.

## Claims Procedure

### Filing a Claim

If you (or your beneficiary) feel you are entitled to benefits from a plan that you are not receiving, you may file a written claim with the claims administrator or plan administrator in accordance with a plan's specific claim filing procedures. The claims procedures applicable to each group health plan are included in the Medical Plan section. The claims procedures for certain insured benefits are described in each applicable section. Where specific claims procedures are not described in a specific section of this Handbook, the following procedures apply.

### Notification of Your Claim

You will receive a response to your claim from the claims administrator or administrative committee within 90 days after your claim is submitted. This time limit may be extended for another 90 days in special cases. You will be contacted if this is going to occur. This notice will explain why extra time is required and the date you can expect a decision.

### Claim Denial

If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial and appropriate information about the plan's claims review procedures.

### Appealing a Denied Claim

If your claim is denied and you wish to appeal, you must file your appeal with the claims administrator within 60 days (180 days in the case of disability benefit claims) of the date of the denial notice. Your appeal should include any additional information that you wish to be considered. If you fail to appeal within the required time period, you are considered to have permanently waived and abandoned your claim and you may not reassert it in a court or any other venue.

The claims administrator will notify you in writing within 60 days (or 120 days in some cases) after your appeal is received. This decision will be final and will be communicated to you in writing.

The claims procedures for certain of the Company's plans may contain different time frames than those provided above. You may obtain a copy of each plan's claims procedures, without charge, upon request.

Unless you have exhausted your rights under a plan's claims procedure, generally you may not file a lawsuit against the plan for benefits. You must bring a lawsuit for benefits no later than one year after the final decision on your claim under these claims procedures. If you fail to file a lawsuit within the required time period, you are considered to have permanently waived and abandoned your claim and you may not reassert it in a court or any other venue.

## Your Rights Under ERISA

As a participant in an ERISA- covered plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- receive information about your plans and benefits.
- examine, without charge, at the plan administrator's office and at other specified locations (such as work sites and union halls), all plan documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.
- receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report for each welfare plan and the Labcorp Employees' Retirement Savings Plan. For the Labcorp Cash Balance Retirement Plan, an annual funding statement is provided.
- obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you must work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.
- continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under a group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

## ERISA Duties

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operation of the plan. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under any Labcorp plan or for exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

## Enforcing Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court once you have exhausted the plan's internal claims procedures. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse a plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the other party to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the plans described in this Benefits Handbook, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or at the following address:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit a mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not more than 48 hours (or 96 hours).